FREE
3 Hours
Category 1 CME Credit
Self-Assessment Test Inside

Medical Examiners' Handbook

Impairment Ratings and Independent Medical Examinations in Washington State Workers' Compensation

for IME Examiners, Attending Doctors and Consultants

AMERICAN COLLEGE OF OCCUPATIONAL AND ENVIRONMENTAL MEDICINE

FREE 3 HOURS CATEGORY 1 CME CREDIT
Complete and Return Self-Assessment Test Inside

This activity has been planned and implemented in accordance with the Essential Areas and Policies of the Accreditation Council for Continuing Medical Education through the Joint Sponsorship if the American College of Occupational and Environmental Medicine and the Department of Labor and Industries.

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Preface

Dear Provider,

The Department of Labor and Industries (L&I) would like to thank you for providing independent medical examinations (IMEs) and impairment ratings for our workers. You play a crucial role in the Washington State workers' compensation system for both State Fund and self-insured employers. Knowing you use the best available medical information, we rely on your unbiased, objective examinations and ratings to help us administer claims effectively and fairly. We work together to serve all workers with dignity and respect.

The Revised Code of Washington (RCW) states that L&I must develop appropriate standards. We want to offer you clear, understandable information and answer your questions about these medical standards. We hope you will find this new edition of the *Medical Examiner's Handbook* (*MEH*) useful and helpful.

This revised edition of the *MEH* is significantly different from the one published in September 2000. It contains the new rules in the Washington Administrative Code (WAC); much information that was once policy is now in the rules. This handbook will help you to understand these changes.

You will note that this edition offers you the opportunity to receive Continuing Medical Education credits by taking the assessment test contained in this handbook. Not only will the test help you fulfill the WAC regulation of becoming familiar with the handbook, but you will also receive category 1 credit for doing so.

We hope the new format helps you find the information you need quickly. Use the index in the back freely. If you have suggestions for ways to make this book even more usable, please let us know. We will consider them for the next edition. Please send your comments to Hal Stockbridge, MD, MPH, Office of the Medical Director, Department of Labor and Industries, PO Box 44321, Olympia, WA 98504-4321.

Throughout this book we refer to other L&I publications, such as the *Attending Doctor's Handbook* (Form #F-252-004-000). You may obtain copies of this and other publications by contacting an L&I Location or the L&I Warehouse at P.O. Box 44843, Olympia, WA 98504-4843. You may also order publications online at www.LNI.wa.gov/formpublications.

For more information about L&I, the Office of the Medical Director and Health Services Analysis, visit L&I's Internet: www.LNI.wa.gov.

Thank you for your services and interest.

Sincerely,

Gary Franklin, MD, MPH, *Medical Director*

Hal Stockbridge, MD, MPH, *Associate Medical Director*

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Section I:
Background - Independent Medical Examinations (IMEs)

Approximately two-thirds of Washington's workers receive coverage from the Washington State Fund administered by L&I. We also manage the Crime Victims' Compensation Program, covering claims for victims of violent crimes.

Self-insured employers insure the other approximately one-third of Washington workers. The same laws that apply to employers of the Washington State Fund apply to self-insured employers. L&I's Self-Insurance Section oversees management of claims by self-insured employers.

When every worker's claim is handled in a fair, professional way, we can ensure that workers and employers receive the stipulated benefits provided under Washington State law.

How can this handbook help me?

Washington Administrative Code (WAC) states that you must be familiar with the contents of this handbook. [WAC 296-23-347 (1) (a)] We understand that your time is limited; however, reading this handbook can help you understand our needs and prevent errors. Performing IMEs requires considerable judgment and understanding of specialized terms and a mastery of skills that may not be part of your original training. Also, you can earn three Continuing Medical Education category 1 credits by completing the assessment test included in this publication.

This guidebook can help you understand Washington State's industrial insurance system and the requirements for high-quality IMEs. Keep in mind that other systems—private, federal, and other state systems—may use different definitions and rules for determining impairment and disability. Please take the time to read this guidebook before you begin performing IMEs. You will:

- Save time,
- Learn new requirements,
- Prevent errors,
- Become familiar with new terms and skills, and
- Earn continuing education category 1 credits.

What are some reasons L&I may ask me to perform an IME?

A claim manager or a self-insured employer orders an IME, sometimes in response to a request or issue raised by the attending doctor, the worker or the employer. The purpose of the exam is to establish clinical observations and conclusions about the worker's condition. Then we can provide appropriate assistance and administrative decisions about the claim.

Some of the reasons we may request an IME may be to:

- Establish a diagnosis. Prior diagnoses may be controversial or ill-defined;
- Outline a treatment program—where treatment or progress is controversial or where treatment has been given for an extended period of time;
- Evaluate what conditions are related to the injury or disease/illness;
- Determine whether an industrial injury or occupational disease/illness has worsened a preexisting condition and the extent of that worsening;
- Establish when the injury or disease/illness has reached maximum medical improvement;
- Rate any permanent impairment, based on the loss of bodily function, or the extent of total bodily impairment (category rating) when maximum medical improvement has been reached;
- Evaluate whether the injury or disease/illness has worsened; and/or
- Determine the worker's ability to return to work after an industrial injury (perform physical capacities evaluations and review job analyses).

Why is it important that I conduct a high-quality IME?

If you conduct a high-quality IME, you will help protect the rights of workers and employers in Washington State by making it possible for L&I to adjudicate claims fairly and effectively. In addition, it saves time and money for all parties because fewer addendums or letters of clarification are needed.

May I waive the patient-physician privilege?

Statute RCW 51.04.050 allows you to waive the patient-physician privilege in industrial insurance cases. Clinical observations are for the benefit of all parties involved: the worker, employer, attending doctor, and/or L&I.

How should I handle confidential information?

Health Insurance Portability and Accountability Act (HIPAA) requires the health care industry to protect the security of stored health care records and those transmitted electronically. All of L&I's programs are exempt from HIPAA Privacy Rule regulations. You may disclose personal health information to the department or self-insurer without an authorization from the worker, and without violating HIPAA.

Due to HIPAA regulations, please do not send claim numbers attached to names over the Internet. You may send them over the secure web site; then follow up with a standard e-mail advising the project team member to check the secure web site for claim information. If you are sending claim numbers only, you may send them over the e-mail. It makes no difference whom you are e-mailing; this policy applies to all cases.

In addition, HIPAA allows you to disclose personal health information without an authorization directly to employers regarding work-related illnesses or injuries. This fact means that, for example, you can release information about the worker's physical restrictions to an employer who may have light-duty work available.

Although L&I is exempt from HIPAA, we have made our billing system compliant so that you can continue to bill us electronically. We have also adopted prudent privacy practices to protect Personal Health Information (PHI). For more information on HIPAA, refer to L&I's HIPAA web site: www.LNI.wa.govgov/ClaimsInsurance/Providers/InjuredWorkers/HIPAA/.

L&I has stricter confidential safeguards for the release of sexually transmitted disease (STD) information than usually apply to other medical conditions. A general authorization to release claim information is not adequate for the release of STD information. A specific medical release from the worker is required for release of STD information.

The following information and test results are considered confidential and should **NOT** be mentioned in your IME report unless the **claim** is for HIV/AIDS and or STD.

- Positive **and** negative information **and** test results related to HIV/AIDS; **and**
- Any positive STD information and test results.

If you feel such information is critical to support your conclusions, contact the claim manager and explain the situation. The claim manager may request that you provide the information in an addendum. Label the addendum "**CONFIDENTIAL**" in a conspicuous position on each page. The claim manager will take steps to ensure that the addendum is kept confidential. If you have questions about the confidentiality of the information, contact the claim manager.

How do I work with State Fund claims?

Requests: Examination requests may come from the worker's claim manager. Sometimes the attending doctor will ask the claim manager for an IME (for example, when the attending doctor prefers not to provide an impairment rating). Direct your reply and any clarifying questions you may have to the claim manager whose name appears on the examination request letter. When L&I requests an IME, the report becomes the property of the department.

Returning reports and bills: For State Fund claims send the ***report*** to address #1 inside the back cover, and send IME-related ***bills*** to address #2 inside the back cover.

State fund claim numbers are preceded by one of the following: B, C, F, G, H, J, K, L, M, N, P, X, Y or AA.

How do I work with self-insured claims?

Requests: Examination requests may come directly from several sources: self-insured employers, their representative companies handling their claims (Third Party Administrators or TPAs) or from L&I's Self-Insurance Section.

Returning reports and bills to self-insured employers: Mail the ***report*** to the person who requested the examination and ***bill*** as instructed.

Returning reports and bills to L&I Self-Insurance Section: The address for returning the ***report*** is L&I's Self-Insurance Section, item #4 inside the back cover of this handbook. Send the ***bill*** for the examination to the self-insured employer listed on the examination assignment letter.

For further information for working with Self-Insurance and State Fund, see the ***Attending Doctor's Handbook.***

Self-insured claim numbers are preceded by one of the following: S, T, W or SA.

How do I work with crime victims claims?

Background: The Crime Victims Compensation Program (CVCP) manages claims for victims of violent crimes who have exhausted other means of payment. Benefits are similar to workers' compensation benefits, and the program uses independent medical examinations to resolve similar adjudication issues.

General requirements are the same as when working with the Washington State Fund.

Of the approximately 3,943 crime victims receiving benefits during 2003, CVCP provided medical and/or counseling for 3,536:

- 2,070 or 58.5% were women and children.
- 784 or 22.2% were related to sexual assault.

The CVCP uses a wide range of specialists to provide IMEs. These evaluations assist the claim manager in managing controversial or complex issues. The program prefers specialists, especially those providing psychiatric or psychological opinions, who have had training and clinical experience in treating crime-related trauma victims. Please carry out these exams with consideration and sensitivity to the needs of the victim. Because the needs of the victim may be greater than the average worker, the exam may take you longer to complete, and the report may require more detail than does the standard IME format.

Requests: Examination requests come from the worker's claim manager. Direct your reply and any clarifying questions you may have to the CVCP claim manager whose name appears on the examination request letter.

Returning reports and bills: You should send both *bills* and *reports* to the addresses listed on the inside of the back cover, item #5. **Make sure reports and bills are separate** and sent to the correct address.

Crime Victims' claim numbers are preceded by one of the following: VA, VB, VC, VH or VK.

Where do I find the rules (Washington Administrative Code - WACs) and laws (Revised Code of Washington - RCW)?

Throughout this handbook we frequently paraphrase WACS and RCWs. We cite WAC and RCW numbers for your reference. You may review the full text of these rules and laws as follows:

Impairment Rating Section 5
WACs regarding impairment rating of body systems.
Pages V 7-42

Appendix C
Relevant Laws and Regulations
Pages C 1-14

You may also find these and other WACs and RCWs at www.LNI.wa.govgov.

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Section II:

The Independent Medical Examination

PART ONE: How can I become an IME provider?

Who may perform IMEs?

Only doctors who have active IME provider numbers can perform IMEs for Self Insurance, the State Fund, or Crime Victims Compensation Program. An IME provider number is NOT the same as a provider number that allows the provider to care for injured workers.

A provider (person, firm or group) must apply for and receive at least one IME provider number in order to be paid for performing IMEs; to qualify for the IME provider number, the following criteria must be met:

- A provider must maintain a current license to practice in the state in which he or she performs exams, and
- Have either:
  - Board certification in his or her specialty, or
  - Full-time or part-time (average of eight hours or more per week in the past two years) active practice involving direct patient care in your medical specialty, excluding IMEs.
- Only providers in the following specialties will be considered:

Doctor is licensed to practice:	Medicine & Surgery	Osteopathic Medicine & Surgery	Podiatric Medicine & Surgery	Chiropractic	Dentistry
In Washington	Yes	Yes	Yes	Yes	Yes
Not in Washington	Yes	Yes	Yes	No	Yes

- The department accepts certifications from boards recognized by the following as meeting the board certification requirements in WAC 296-23-317:
  - American Board of Medical Specialties;
  - American Osteopathic Association (AOA) Bureau of Osteopathic Specialties;
  - American Podiatric Medical Association; or
  - American Dental Association.

Limited license providers (for example, dentists, podiatrists, and chiropractors) may only provide ratings for body regions (areas) or conditions within their scopes of practice.

IMEs and impairment ratings are **not** the same. See Pages V 1-42 for information on rating impairment.

The department's medical director also considers other factors when approving an IME provider application, such as the following:

- Any action against a provider's license,
- Complaints about the provider,
- Quality of reports,
- Timeliness of reports,
- Charges of any criminal offense, and/or
- Convictions of any criminal offense.

If you are licensed to **practice chiropractic** in Washington, then you must also meet the following requirements to be paid for performing IMEs and impairment ratings:

- Be a chiropractic consultant for L&I for at least two years;
- Take an impairment rating course approved by L&I; and
- Attend both of L&I's chiropractic consultant and examiners' seminar during the 24 months prior to sending in your application.

The department may order an examination by a single approved IME chiropractor under the following circumstances:

1. A chiropractor has exclusively provided treatment for the care of an injured worker.
2. The current attending doctor is a chiropractor, and the care has been only for spinal soft tissue injury (no fracture, spinal cord injury, etc.).
3. No surgery has been performed even though medical care was provided prior to chiropractic care.
4. A claim reopening is requested, clinical findings for reopening need clarification, and no preexisting, non-spinal or temporary conditions are in evidence. In these circumstances it is expected that only standard or limited levels of examination would be requested.

All doctors must also fulfill all business requirements stated in the rules [WAC 296-23-317 (5)]. See also Pages II-3, Appendix A.

If I have a change in my qualifications as an IME examiner, what must I do?

Immediately notify L&I **in writing** of any change in your status that might affect your qualifications to hold an IME provider number. If applicable, providers must include a copy of **any** charges or final orders. Changes in status include **any one** of the following:

- Changes in amount of time spent in direct patient care, excluding IMEs;
- Loss or restriction of hospital admitting or practice privileges;
- Changes affecting business requirements;
- Loss of board certification;
- Charges regarding any criminal actions;
- Convictions of any criminal actions; or
- Temporary or permanent probation, suspension, revocation, or limitation on license to practice in any state or foreign land. [WAC 296-23-3321]

What are the training requirements as an IME examiner?

Attending seminars and courses given by the department is important. You must stay current with the new regulations and policies of the department in order to remain a department-approved IME provider. Failure to stay current in your specialized area and in the areas of impairment rating, performance of IMEs, industrial injury and occupational disease/illness, industrial insurance statutes, regulations and policies can mean possible suspension or termination of your IME provider number. [WAC 296-23-337 (9)]

In order to stay current, it is useful to complete at least 12 credit hours of continuing education every three years in the field of industrial insurance or detection of occupational disease in your specialty area.

Chiropractors: L&I requires certain training for chiropractors. [WAC 296-23-317 (4)] When you complete the IME Provider Account Application, you are required to have completed an impairment rating course for Washington State, as approved by L&I. (See Page A 1-2 for IME Provider Application information.) You also are required to have attended the department's annual chiropractic consultant or IME examiners' seminar in the previous 24 months prior to applying.

Training courses are available from other sources. The department does not endorse any specific training course. Training on the use of the American Medical Association *Guides to the Evaluation of Permanent Impairment* (AMA *Guides*) is available through several sources (including, but not limited to):

- The American College of Occupational and Environmental Medicine (ACOEM), 55 West Seegers Road, Arlington Heights, Illinois 60005-3919; 847-228-6850, ext. 154 or ext. 190
- The American Academy of Disability Evaluating Physicians (AADEP), 150 North Wacker Driver, Suite 920, Chicago, Illinois 60606 1-800-456-6095
- SEAK, Inc., PO Box 729, Falmouth, MA 02541; 508-457-1111

These courses do not include information about the Category Rating System.

L&I offers courses, which cover both the AMA *Guides* and the Category Rating System. For information on these courses, contact L&I's Provider Education Manager, #8 inside the back cover, or L&I's web site at www.LNI.wa.gov.

How do I apply to become an IME provider, if I do not already have an IME provider number?

To apply for approval as an independent medical examiner, you must complete an application and submit the details and materials required by the department. You will find a complete explanation of this process in Appendix A.

What if I want to perform IMEs with independent medical examination firms?

IME firms or medical groups (panels) are organizations that have scheduling and billing relationships with multiple providers who provide examinations. Rules, however, state that you must have an **individual provider number for each firm** you work for. If you work for a firm, it is your responsibility to submit your application containing accurate information, including the firm's information.

Firms must also apply for approval to provide IMEs.

To receive approval, the IME firm, partnership, or corporation must have a medical director. This director must be a licensed provider who provides oversight on the quality of IMEs, impairment ratings and reports [WAC 296-23-317 (5) (e)].

See Appendix A for further requirements for IME firms.

What is an agreed exam?

An agreed exam is an independent medical examination in which the claim adjudicator and the worker's legal representative select an approved IME examiner(s) to conduct an IME and agree that each party will abide by the findings, conclusions, and recommendations. The

employer must approve or authorize the agreed exam when the employer is active in the claim.

State Fund claim managers do not use agreed exams; however, claim consultants and pension adjudicators may use an agreed exam to settle a claim.

PART TWO: What do I need to know and do before the examination?

What should I do if documents are missing from the file?

You must review and be familiar with all claim documents provided to you. If some **materials are missing or seem incomplete**, contact your referral source before the IME. The referral source will try to obtain them for you before the appointment with the worker.

What should I do before the examination?

- Contact the worker prior to the exam to confirm **appointment date, time and location**. (The IME firm/panel may perform this service if you work for a firm.)
- Review the purpose of the exam and the questions you will answer in the exam report.
- Provide sufficient time to evaluate fully the provided records.
- Be aware of the contents in the State Fund brochure entitled *Your IME Exam* that the worker receives in the mail before the visit so that you may answer questions, if necessary. You may find this brochure at this web address: www.LNI.wa.govgov/ClaimsInsurance/Providers/IME/Brochure/default.asp

What must I know about site standards and business requiriements?

You must provide your medical examinations only in a professional office suitable for medical, podiatric, chiropractic or psychiatric exams where the primary use of the exam space/room is for medical services—not for residential, recreational, commercial, educational or retail purposes.

Make sure that the site contains adequate:

- Access,
- Climate control,
- Light,
- Space,
- Equipment for comfort and safety of the worker,
- Privacy for discussion of medical needs,
- Private disrobing area,
- Provision of examination gowns,
- Telephone answering capability during regular business hours (and on Saturday, if open), and
- Compliance with all federal and state laws, and regulations, with regard to business operations. [WAC 296-23-317 (5)]

Who provides an interpreter?

Workers may not bring their own interpreters to the exam. If the worker needs an interpreter to communicate because of limited English-speaking ability or sensory impairment, **the department, Crime Victims Compensation Program, or the self-insurer will provide one.** We will **not** pay family members or friends of the worker to act as interpreters. [WAC 296-23-362]

Who is allowed to attend an IME ?

The worker can bring an adult friend or family member to the IME to provide comfort and reassurance. However, no one, except an interpreter, if needed, may accompany the worker in a psychiatric exam.

The purpose of an IME is to gather information, not to conduct an adversarial proceeding. Therefore, the friend or family member, must quietly observe the exam, cooperate with the examiner and not interfere.

The following WACs apply to examinations requested by L&I, CVCP and self-insured employers.

WAC 296-23-362

May a worker bring someone with them to an independent medical examinination (IME) ?

(1) Workers can bring an adult friend or family member to the IME to provide comfort and reassurance. That accompanying person may attend the physical examination but may not attend a psychiatric examination.

(2) The accompanying person cannot be compensated for attending the examination by anyone in any manner.

(3) The worker may not bring an interpreter to the examination. If interpretive services are needed, the department or self-insurer will provide an interpreter.

(4) The purpose of the IME is to provide information to assist in the determination of the level of any permanent impairment not to conduct an adversarial procedure. Therefore, the

accompanying person cannot be:

(a) The worker's attorney, paralegal, any other legal representative, or any other personnel employed by the worker's attorney or legal representative; or

(b) The worker's attending doctor, any other provider involved in the worker's care, or any other personnel employed by the attending doctor or other provider involved in the worker's care.

The department may designate other conditions under which the accompanying person is allowed to be present during the IME.

May the Worker Record the IME?

No. WAC 296-23-367 does not allow the worker or an accompanying person to record the IME electronically (audio or video).

How are IMEs scheduled?

Examiners may choose to provide IMEs individually or through firm affiliations. Those examiners choosing to arrange, conduct and bill for IMEs themselves work directly with the schedulers/claim managers. Those examiners affiliated with (a) firm(s) are scheduled through their designated firm(s) and often conduct the exam at a site provided by the firm(s). The firm(s) also facilitate(s) many other facets of the exam, such as billing and report preparation.

L&I State Fund and Crime Victims Compensation Program (SF and CVCP) usually follow this process when scheduling an IME:

- L&I claim managers determine when an IME is needed.
- The referral source (claim manager) determines the following:
    - whether one or more specialist is required for the IME,
    - whether a certain type of specialist is needed, and
    - when the IME is a priority, such as reopening a claim.

Claim managers will select the appropriate specialty type to conduct the IME. Most IMEs will require only one examiner. In some cases, more than one examiner may be requested, particularly when multiple body systems are involved. For example, a neurologist, a rheumatologist, and a psychiatrist may make up a team of examiners who are asked to examine a worker who sustained an industrial injury to the cervical spine, has received treatment for depression and is contending a diagnosis of fibromyalgia as causally related to the industrial injury.

- The claim manager provides a summary of the claim and identifies the issues and questions that should be answered for each IME ordered. If the worker needs special accommodations, such as an interpreter or travel arrangements, the centralized scheduling unit (CSU) makes the arrangements for State Fund and Crime Victims' claims.
- The centralized scheduling unit (CSU) schedules IMEs for State Fund and Crime Victims' claims.
- The unit scheduler receives the IME request and accesses an Intranet search to find the type and number of specialist(s) requested by the claim manager.
- The unit scheduler schedules the IME.

Self-insured employers perform the same steps in searching for an IME-approved examiner through the L&I Internet site. They then arrange for their own IMEs.

This web site may be accessed at www.imes.LNI.wa.gov. Then select "Find a Medical Examiner."

PART THREE: What do I need to know and do during the examination?

What responsibilities do I have to the worker?

Beginning the examination

- Conduct the exam with dignity and respect for the worker.
- Provide a setting for an IME in a professional setting (office) suitable for medical, podiatric, chiropractic or psychiatric exams. (See Page II-3 for more details on "Site Standards.")
- Introduce yourself to the worker. A name tag may be helpful, especially if there is a language problem. The worker has a right to know your name and specialty.
- Verify the identity of the worker by asking for a name and/or identifying picture.
- Tell the worker that you have received and reviewed the claims documents from L&I or the self-insurer.
- Explain the examination process, purpose of the exam and how an IME and personal doctor's visit differ.
- If the worker has brought x-rays or MRIs to the exam, acknowledge receipt of them in your report.
- Explain the examination procedure.

- Answer the worker's questions about the examination process. (Refer the worker to the claim manager for questions about the claim and to the attending doctor for medical advice outside the scope of your examination.)
- Advise the worker that he/she should not perform any activities beyond the worker's physical capabilities. Ask the worker to inform you should pain occur.
- The worker must be fully dressed while you take the history.
- Provide adequate draping and privacy if the worker needs to remove clothing for the examination.
- Allow an adult friend or adult family member to attend non-psychiatric portions of the examination. (See "Who is allowed to attend an IME?" on Page II 3-4.)

During the examination

- Refrain from comments about the care the worker has received. While we may ask for your opinions later, please don't express opinions during the exam process. If you feel the worker has had inadequate care, make appropriate written comments. (See "What if the injured worker needs treatment from a different provider?" Page III-4.)
- Refrain from expressing personal opinions about the worker, the employer, the attending doctor or L&I.
- Conduct an exam that is unbiased, appropriate to the condition being evaluated, and sufficient to answer the referral questions.
- Respond to all questions asked by the worker in an objective and professional manner, without regard to the outcome of the evaluation.

Closing the examination

- Close the exam by telling the worker that the exam is over and ask whether the worker would like to know more information or ask further questions. A worker who feels that he/she is not given a chance to ask questions is likely to feel dissatisfied and believe that the exam is incomplete.
- Inform the worker that you will send the report directly to the claim manager.
- If needed, explain that you feel the necessity of ordering further diagnostic tests for the worker.
- Tell the worker how to contact the claim manager for questions (1-800-LISTENS). [WAC 296-23-347]

Should I discuss the examination results with the worker?

You may briefly discuss the results of the exam with the worker if you choose. Record in your report that you have provided some summary comments to the worker's concerns. Remember that an attending doctor may discuss with the worker the IME report and any appropriate treatment, if needed.

Do not advise the worker on benefits (such as time-loss compensation or vocational services). Refer the worker to the claim manager.

May I offer to provide ongoing treatment?

No. The rules state that you should not offer to provide ongoing treatment. However, if a worker voluntarily approaches an IME provider who has previously examined the worker and asks to be treated by that provider, the provider can treat the worker. The provider must document that the worker was aware of other treatment options.

L&I or the self-insured employer must approve transfer of care. With only a few exceptions, the patient has free choice of a treating doctor. [WAC 296-20-065]

PART FOUR: What do I need to know and do <u>after</u> the examination?

How do I order diagnostic tests?

All tests must be proper, medically necessary and related to the industrial injury. Follow the instructions in the referral letter regarding diagnostic testing. In many cases the letter will give you authorization to ask for certain tests. You should simply arrange for the **needed routine test(s)** (laboratory or x-rays) and complete the IME report after you receive the test results **(l4 calendar days**). See Page III-1 for information about deadlines. MRIs do not require authorization. **Refer invasive testing to the attending doctor** who should arrange for such testing (e.g., myelogram, biopsies, etc.).

What should I do if the examination is incomplete?

If you were unable to complete an examination due to the worker's condition or behavior, contact the claim manager immediately, and then write a report to the claim manager who requested the examination.

What must I do if I think I need an additional examiner?

If you need an additional specialist to complete the exam, include your reasons why in your report. The claim manager will decide whether another specialist is needed after reviewing your report and recommendation.

What should I do if the worker cancels or does not show up?

If the worker calls to cancel an appointment or fails to show, you should contact the person who scheduled the exam. The scheduler's contact number will be on the examination assignment letter. It may be possible to reschedule the missed exam. Retain the worker's file and examination assignment (and IME referral letter) until this matter has been resolved.

In some circumstances a cancellation or no-show fee is appropriate. See the *Medical Aid Rules and Fee Schedules*, published on CD and Internet: www.LNI.wa.gov/claimsinsurance/providerpay/feeschedules. Click on "Claims Insurance/Provider Pay."

Should I release reports to other parties and respond to correspondence and phone calls?

If you receive correspondence or phone calls from parties other than the claims staff or the attending doctor before the examination and completion of the exam report, direct these communications to the worker's claim manager. You may get questions from other parties regarding your findings. In such cases, you may release information if you are comfortable with the request and you have the appropriate release forms, **but only after the report has been submitted to the department or self-insurer.**

After you complete the examination, submit this report to the party that requested the exam. On occasion, the exam assignment request will ask you to forward this report to parties involved in the claim (i.e., the attending doctor or the vocational counselor). In such cases you **must** send a copy of the exam report as directed. Keep one copy of this report for your records.

When other parties express interest in obtaining a copy of the exam report, unless you are directed otherwise, advise them to contact the department or self-insured employer to obtain a copy. It is standard procedure for the department to send this report to the attending doctor and the worker's legal representative, once it is received in the department. In addition, these reports are available to the employer assigned to the claim. If the department has the appropriate medical release, we will send this report to additional interested parties on request. The worker also may request a copy. There is no charge to receive one copy of the exam report from the department or self-insurer.

Even if you have a signed release from the worker, it is generally best if you direct the worker to the claim manager or to the attending doctor for a copy of the report. Once you have submitted the exam report to the department, if you are comfortable with the request for a copy of the exam report and you have the appropriate release form from the worker, you may release this report to any other parties. You may charge a copying fee to parties other than the insurer's staff and the attending doctor.

If you are unsure about the validity of a request, it is always appropriate to check with the worker's claim manager. For State Fund claims you may call the **Provider Hotline at 1-800-848-0811**. (The number to call from outside Washington is 1-800-547-8367.) Be sure to reference the claim number and the worker's name to receive claim status information. For self-insured and crime victims claims call the referral source.

How should I maintain and dispose of health records?

For audit purposes you must maintain all health records that show the extent of services you provided the worker. Document the level and type of service for which you seek payment. You must **maintain these documents for a minimum of five years**. [WAC 296-20-02005]

Then discard the worker files in the manner you dispose of other health records that you have in your office.

Remember to return x-rays and other imaging studies to the worker, hospital or the office that provided them, unless they have directed you not to return them.

Where can I refer workers so that they may ask questions about their claims?

Refer the workers to their claim managers if they have questions about the claim or workers' compensation benefits.

The L&I toll-free number for workers is 1-800-547-8367 (1-800-LISTENS) or 1-800-831-5227.

Part Five: How does the department evaluate complaints about the quality of my examinations and reports?

How does the department handle complaints from workers about IMEs?

Workers may send written complaints about your conduct during their IMEs to L&I. The Provider Review and Education Unit tracks the number and type of complaints received.

L&I's Provider Review and Education Unit reviews complaints about approved examiners. In most cases, we will send you a copy of the complaint so that you are aware of how you were perceived. This gives you the opportunity to respond to the complaint.

Based on the nature of the complaint, we may refer the complaint to the Department of Health. [WAC 296-23-372] Complaints alleging physician malpractice, substance abuse or sexual abuse are forwarded to the appropriate section of the Department of Health, such as the Medical Quality Assurance Commission.

How does the department handle other complaints about IMEs?

We receive complaints from a variety of other sources, including claim managers and attending doctors. The department handles complaints about your examinations and reports differently than complaints from workers.

If we receive complaints about poor report quality or late reports, the Provider Review and Education Unit may review your reports and contact you for remedial action. The department bases its review on the quality of the examination and report, not on whether your recommendations are perceived as favorable or unfavorable to the parties involved.

Based on complaints, what other action could the department take?

The department could suspend or terminate your IME provider number if a consistent pattern of complaints develops, as illustrated in the following examples:

- Worker complaints, such as rudeness, lack of respect, unprofessional behavior;
- Poor examination and report quality;
- Late reports;
- Action taken by the Department of Health against your license to practice;
- Unwillingness to testify or inability to substantiate your opinions before the Board of Industrial Insurance Appeals.

If the department suspends or terminates your IME provider number, you will receive no further IME referrals. You can find a complete list of reasons for suspension/termination in WAC 296-23-337; the above list contains only a few of the reasons for termination as an approved IME examiner.

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Section III:

The IME report

PART ONE: Generally, what must I know about an IME report?

Your IME reports will make a difference—a significant difference—for the workers, the employers, the claim managers, the attorneys, the vocational counselors and others. Your report will help to determine whether the workers will receive the correct, lawful benefits due them when claim managers make decisions or when someone disputes a decision. Your report must contain unbiased, accurate, sound, and comprehensive information, obtained through a high-quality examination that respects the dignity of the worker. We rely on you.

What are the time frames for IME reports?

Note: The rules state that the IME report must be sent within fourteen (14) calendar days of the exam [WAC 296-23-347 (a)]. Failure to provide reports within this period may result in adjustment of payment amount or other penalties. In exceptional cases (e.g., you are holding the case for special study results), notify the claim manager of the reason for the delay as soon as possible.

Special circumstances may exist when the claim manager must have the report in order to meet statutory deadlines. The exam assignment notice will indicate the date you must submit the exam report. If you are unable to meet this deadline, notify the claim manager immediately.

What must I include in an IME report according to rule?

The rules [WAC 296-23-382] state that an IME report must:

- Contain objective, sound and sufficient medical information;
- Document the review of the claim documents provided by the department or the self-insurer;
- Document the worker's history and the clinical findings;
- Answer all the written questions posed by the department or self-insurer or include a description of what would be needed to address the questions;
- Include objective conclusions and recommendations supported by underlying rationale that links the medical history and clinical findings;
- Be in compliance with current department reporting policies; and
- Be signed by the IME provider performing the examination.

Failure to provide reports with these contents may result in non-payment, recoupment (holding monies from future payments) or other penalties.

Appendix B includes sample reports to help illustrate what we would like to see in your IME report.

We do not require that you use the format and template shown in Sample Report # 1, but we strongly recommend it. **We require, however, that IME reports contain all the report elements except those marked by an asterisk (*).** You should only include those marked by an asterisk if the claim manager has specifically requested you to do so. Review your report to see that it is complete. The L&I Provider Review and Education Unit will look for these elements when reviewing the quality of your documents.

Please make **each examination report unique** to reflect your individual consideration.

How much detail should I include in my report?

Other health care professionals often scrutinize your IMEs. Remember that your duty is to reduce conflict by being objective and including data that will allow reviewers to understand your conclusions. Areas of the history and physical exam in which detail is often lacking, include portions that deal with pain, swelling, range of motion and skin eruptions. When one or more of these are part of the history or physical exam, you should discuss the following points:

- **Pain**: nature and quality; radiation; severity (including scale); ameliorating/exacerbating factors; effect on activities; etc.
- **Swelling**: location; shape; dimensions;

color; etc.

- **Range of motion**: joint (right or left); measurement, for example, with a goniometer (not required, but helpful)
- **Rash**: location/distribution; character (e.g., macular, papular, urticarial), etc.

Why are fair, unbiased reports so important?

Employers, the labor community, the legislature, L&I—all want IME examiners to make a special effort to provide fair, unbiased reports.

Why? Biased reports may create significant problems for all parties involved. For example, biased reports may affect the health of the worker and the operation of the employer's business, not to mention that they may lead to litigation, resulting in costly delays and high legal expenses. Protests create administrative problems for claim managers, so adjudicators prefer reports that neither overstate nor understate workers' impairment.

See also Section II, Part five, Page II-7.

How should I sign the IME report?

Sign the end of the report to document that each examiner has approved the content. **A separate signature page is not acceptable.**

Where must I mail my IME reports?

You must use **different addresses** for State Fund, Self-Insurance and Crime Victims' reports. See the inside of the back cover of this book for addresses.

For State Fund: Do <u>not</u> attach or staple your bills to your reports. <u>Send bills and reports to different addresses.</u> See the inside of the back cover for addresses. If you send medical reports to the billing address, the report may not reach the claim manager. A post office box number makes a big difference in our mail delivery.

What must we do if examiners disagree on IME conclusions?

Multiple-examiner IMEs should be conducted at the same site on the same day as much as possible. This helps avoid disagreements on the conclusions in the report.

Claim managers rely on the examiners' reports to help make their decisions. If IME reports contain widely divergent opinions, the claim managers have trouble making decisions about cases. All examiners, therefore, must consult and discuss their findings with all other examiners while preparing the IME report. If differences of opinions exist among examiners, the IME report must discuss the reason for the differences of opinion and provide options, if appropriate. Remember, as stated above, all examiners must sign the report after it is completed, certifying that the report accurately represents their findings and opinions.

What is an addendum report?

L&I or the self-insurer may ask you to complete an addendum report after receiving your IME report. If the request asks you to respond to a question that you overlooked in the examination request letter, we expect you to send the addendum report promptly (within 14 calendar days of receipt of the request) for no additional payment.

If we ask you to answer new questions, then you may charge for the report and receive payment. **Return the addendum report within 14 calendar days of receipt of the request.** If you cannot address the new questions based on your record of examination, contact the claim manager to discuss the kind of information needed or identify the additional expertise needed.

How can I be certain I am using legal terms properly?

We want you to have a clear understanding of the words we use in this guidebook. Please use our *Index* to find the terms.

What is meant by 'more-probable-than-not' in an IME ?

We may ask you to determine whether the worker's condition is caused by an industrial injury or exposure on a more probable than not basis. Under Washington law, a causal relationship exists if you find that a **greater than 50 percent chance** exists that the condition resulted from the industrial accident or exposure. Multiple causes may exist in a condition, and the industrial injury or exposure does not need to be the sole cause.

What is "Maximum Medical Improvement (MMI)?"

L&I considers the terms "MMI" and "fixed and stable" to be synonymous. ("Fixed and stable" is the legal term.)

An accepted condition has reached maximum medical improvement (that is, fixed and stable) when it is reasonably certain that further medical treatment will not improve the illness or medical condition.

"Fixed" does not necessarily mean "healed" or "static." Rather, it means the worker has reached a stable plateau from which further recovery is not expected, although the passage of time may produce some benefit.

Where do I find guidelines and policies on specific medical conditions and treatment recommendations?

IME providers must be familiar with the diagnostic and treatment guidelines established by the department. Your opinions should, as much as possible, be consistent with these guidelines.

You may order the *Medical Treatment Guidelines* (F252-010-000) by calling the Provider Hotline at 1-800-848-0811 or visit www.LNI.wa.gov/ClaimsInsurance/Providers/TreatmentGuidelines to find out more about topics such as the following:

- Hospitalization for low back pain
- Cauda Equina
- Knee surgery
- Single cervical nerve root surgery
- Single lumbar nerve root (lumbar laminectomy)
- Ankle/foot surgery
- MRI lumbar spine
- Shoulder surgery
- Lumbar fusion
- Thoracic outlet surgery
- Carpal Tunnel Syndrome
- Psychiatric and psychological evaluation
- Porphyria
- Complex Regional Pain Syndrome (CRPS)
- Fibromyalgia
- Controlled substances
- Outpatient prescription of oral opioids for chronic noncancer pain

L&I issues Provider Bulletins (PB) that explain our policies on many medical issues, medical treatment guidelines, and coverage/non-coverage decisions. You may access these bulletins online at www.LNI.wa.govgov/ClaimsInsurance/Providers/ProviderBulletins.

You may also order our Provider Bulletins by calling the Provider Hotline at 1-800-848-0811 or visit www.LNI.wa.govgov/ClaimsInsurance/Providers/ProviderBulletins/default.asp.

The following is a partial list of current Provider Bulletins. Please check www.LNI.wa.gov/ClaimsInsurance/Providers/ProviderBulletins/default.asp for any subsequent Provider Bulletins not listed in this handbook.

Year 2004

PB 04-05: *Implementation of the Preferred Drug List*

PB 04-01: *Coverage Decisions* (including Bone Morphogenic Protein for Delayed Fractures & Spinal Fusion; Intradiscal Electrothermal Therapy; Bone Cement for Kyphoplasty and Vertebroplasty; and Thermal Shrinkage for the Treatment of Shoulder and Anterior Cruciate Ligament Instability)

PB 04-17: *"Spinal Cord Stimulators (SCS) for Injured Workers with Chronic Low Back and Leg Pain after Lumbar Surgery" Pilot Study*

PB 04-12: *Review Criteria for Thoracic Outlet Syndrome Surgery*

PB 04-10: *Guideline for Cervical Surgery*

Year 2003

PB 03-16: *Review Criteria for Knee Surgery*

PB 03-13: *Bone Growth Stimulators and Tobacco Use Cessation for Spinal Fusions*

PB 03-11: *Guidelines on Facet Neurotomy*

PB 03-09: *Coverage Decisions* (including non-coverage of ERMI Flexionater and Extensionater Devices; non-coverage of Extracorporeal Shockwave Therapy; and non-coverage of the Otto Bock Vacuum Assisted Socket System)

PB 03-03: *Guidelines for the Evaluation & Treatment of Injured Workers with Psychiatric Conditions*

PB 03-02: *Coverage Decisions* (including Autologous chrondrocyte implantation for selected patients; meniscal allograft transplantation for selected patients; Coverage denial of computerized prosthetic knees, but with limited exceptions; and Coverage denial of the UniSpacer)

Year 2002

PB 02-12: *Rating Permanent Impairment*

PB 02-11: *Guideline for the use of Neurontin® in the Management of Neuropathic Pain*

PB 02-06: *Spinal Injection Policy*

PB 02-01: *Criteria for Shoulder Surgery*

Year 2001

PB 01-14: *Recent Formulary Coverage Decisions and Drug Updates*

PB 01-11: *Transcutaneous Electrical Nerve Stimulation (TENS) (see update* **PU 03-01***)*

PB 01-05: *Hearing Aid Services and Devices Reimbursement Policies & Rates*

PB 01-06: *Testing and Treatment of Bloodborne Pathogens*

PB 01-05: *Guidelines for Lumbar Fusion (Arthrodesis)*

Year 2000

PB 00-09: *IDET and Vax-D*

PB 00-04: *Opioids to Treat Chronic, Non-Cancer Pain*

Year 1999

PB 99-11: *Job Modifications and Pre-Job Accommodations*

PB 99-02: *Payment for Job Analysis Review*

Year 1998

PB 98-11: *Fibromyalgia*

PB 98-10: *Hyaluronic Acid in Treatment of Osteoarthritis of the Knee*

Years 1991 through 1997

PB 97-05: *Complex Regional Pain Syndrome (CRPS)*

PB 97-04: *Neuromuscular Electrical Stimulation (NIMES) Device*

PB 96-10: *Exchanging Medical Information with Employers*

PB 95-10: *Carpal Tunnel*

PB 94-12: *Revised Rules for the Evaluation of Respiratory Impairment*

PB 91-01: *Screening Criteria for Surgery to Treat Knee Injuries*

What should I avoid in the examination or report?

Your IME report should not include the following types of items:

- **Statements about the claim status**: Please don't state things like "Keep the claim open. . . .or closed." L&I is responsible for these administrative decisions, and we will use your findings to make them.
- **Speculation about services**: Avoid such statements as, "This worker needs vocational retraining," or "The insurer should pay for this worker to get a high school diploma." Don't comment on vocational issues unless the claim manager specifically asks you to address the worker's ability to work or to perform a specific job. If you are asked to discuss the worker's ability or inability to work in a specific job, focus on the worker's physical abilities and provide complete information regarding any restrictions, including the basis for the restrictions. (See Pages III 9-12.)
- **Inconsistencies**: Make sure no inconsistencies exist in your report, for example, saying the patient has reached MMI but requires six more weeks of physical therapy.
- **Discussion of fault**: Since Washington is a "no-fault" state, avoid discussing fault (anyone's) with the worker. Coverage exists regardless of fault. Your examination report should not determine fault.
- **Discussion of finances**: Do not discuss financial need or assets.

What if the injured worker needs treatment from a different provider?

Under Washington law, workers may choose their attending doctors who may hold licenses in many different areas. Workers may sometimes choose doctors who are not qualified to provide the care that the worker needs. So, in your report recommend the specific treatment and the type of specialist needed. The attending doctor is the one to make the referral.

If you expect that further treatment, such as the type the worker has been receiving, will not be curative, then say this in the report. Avoid statements about the attending doctor that are based on your objection to general principles of a profession or area of specialty.

Can a closed claim be reopened?

If the accepted condition of a worker objectively worsens, a closed industrial insurance claim may be reopened. We may ask you, as an examiner, to perform reopening exams to answer specific questions.

L&I or the self-insurer may arrange for a reopening exam in order to do the following:

- Determine whether the accepted condition has worsened;
- Assess whether further treatment is needed;
- Document objective signs or findings and rate the increased permanent impairment, if appropriate;
- Determine whether the current condition is causally related to the injury or exposure covered under the claim.

Important things for you to do at the reopening:

- Document the findings substantiating any worsening of the worker's condition and the reason for the worsening.
- Describe the activity, if any, that caused the change in objective findings. Examples: Did symptoms start after loading firewood? After bending over to tie a shoe? Where did the activity occur?
- Be sure to review the worker's medical records at the time of last claim closure or last denial of reopening.

When worsening (aggravation) has occurred, an injured worker may be entitled to further treatment or additional compensation, if:

- The causal relationship between the injury and the worker's impairment is established by medical evidence on a "more-probable-than-not" basis; and
- The medical evidence, backed in part by objective findings, shows that the worker's condition worsened; and
- The medical evidence, backed in part by objective findings, shows that the worker's condition worsened since the last closing order. (Check with the claim manager if you are unsure of the closing date.)

  Note: A condition need not worsen enough to increase the impairment rating. Reopening depends on evidence of worsening, regardless of whether or not the impairment rating has increased.

  Note: See Page V 4-5 in the section on Impairment Ratings for further discussion on aggravation of preexisting conditions.

Definition of worsening (aggravation): In workers' compensation, these terms refer to a worsening of the industrial injury or occupational disease that results in the need for further treatment or a temporary or permanent increase in impairment. Industrial insurance cannot cover conditions when other factors cause the worsening, such as an intervening injury, natural progression of a preexisting condition, etc. The opinion that the condition has worsened must be based at least in part on objective evidence (*Wilber v. Department of Labor and Industries, 1963*).

PART TWO: What do I need to know about occupational diseases?

Occupational diseases are different from occupational injuries. Carpal tunnel syndrome, noise-induced hearing loss, dermatitis, and asthma, when work-related, are examples of conditions which L&I considers occupational diseases. The Revised Code of Washington (RCW) defines an occupational disease as an infection or disease that "arises naturally and proximately" out of employment (RCW 51.08.140). For a detailed description of the definition, please see "Criteria for Allowance of an Occupational Disease" on the next page.

Unlike other questions in medicine where 90% or 95% certainty may be preferred for clinical decisions, in the workers' compensation system a degree of certainty greater than 50% is what is required for you to conclude that a condition is work-related on a more-probable-than-not basis.

Claims based on mental conditions cause by stress are excluded by law from this definition (RCW 51.08.142).

Please refer to Sample Report 6 in Appendix B.

Why do claim managers need so much information about occupational disease claims?

Various laws and court decisions have created a legal standard different for occupational disease claims than that which pertains to industrial injuries. These legal aspects make it necessary for claim managers to gather detailed information from approved examiners on occupational disease claims to guide their legal decisions. This additional information is especially vital where several jobs with different employers may have contributed to the diagnosed condition. **In the legal process we may have to apportion or pro-rate the cost of benefits among the multiple employers whose employment contributed to the condition.**

Examples of court decisions include *Dennis v. Department of Labor and Industries* (1987) and *Sacred Heart v. Carrado* (1978). For more detailed information on the criteria for allowance for occupational disease claims, see the box titled "Criteria for Allowance of an Occupational Disease." Since the legal standard is different in occupational diseases, we need additional information from you for occupational claims

Should I submit an extra report for occupational diseases?

IME examiners should ONLY provide this report if specifically requested by the claim manager.

Special billing codes may be used to compensate IME examiners, attending doctors and consultants for the work required to file the extra report called the Doctor's Assessment of Work-Relatedness for Occupational Diseases. Depending on the diagnosis, it may or may not be necessary or appropriate to file this report. Refer to the *Medical Aid Rules and Fee Schedules* for billing codes: www.LNI.wa.govgov/claimsinsurance/providerpay/feeschedules.

Required content: This extra report MUST include all the content illustrated in Sample Report #6 in the Appendix B on Pages B 10-16.

Criteria for allowance of an occupational disease

"Occupational disease" is a disease or infection that arises naturally* and proximately out of employment.** Criteria used by claim managers for allowance of an occupational disease, based on law and regulation, include the following:

a. A physician must present an opinion that work conditions, on a more-probable-than-not basis (a greater than 50% chance), are the cause of the illness or have aggravated a preexisting condition; **AND**

b. Objective medical findings support the diagnosis; **AND**

c. The disease must arise "naturally and proximately" out of employment [RCW51.08.140].

***"Naturally":** To meet the definition of arising "naturally" out of employment *[Dennis v. Department of L&I (1987)]*, a disease must be regarded as a natural consequence of distinctive conditions of the work process, including any of the following:

- The disease is unique to the employment. The disease or disease-based disability could not have been contracted elsewhere. **OR**
- The worker's occupation exposed the worker to an increased risk of contracting the disease. A greater likelihood of contracting the disease or the disease-based disability existed. **OR**
- The disease is caused by continuous and specific activity required to perform the job.

****"Proximately":** To meet the definition of arising "proximately" out of employment, "the cause must be proximate in the sense that there existed no intervening independent and sufficient cause for the disease, so that the disease would not have been contracted **but for** the [distinctive] condition existing in the …employment." *[Simpson Timber Company v. Department of L&I (1949)]* It is not required that the industrial injury or exposure be the only proximate cause of the condition *[Hurwitz v. the Department of L&I (1951)]*. For example, asbestos exposure can be a proximate cause of lung cancer, even though the worker is also a smoker.

PART THREE: How do I complete a psychiatric IME report?

The following describes elements of a psychiatric evaluation and report that are useful in evaluations of injured workers. The format follows a general psychiatric interview, with additional features unique to this setting.

The cover letter you receive from us will contain specific questions. Address each question carefully. Avoid giving information not pertinent to the questions and giving opinions that are not necessary to answer the specific questions.

If your examination includes an impairment rating, follow the instructions in the Mental Health Section on Pages V 32-34.

In your discussion with the worker, it is important to note the following guidelines:

- The evaluation is **not confidential**.
- The purpose of the evaluation is to **provide information regarding the worker's medical/mental condition.**
- You will **not** provide medical treatment or advice to the worker.

The department expects you to conduct a full psychiatric evaluation that should generally include the following:

I. <u>Identifying information</u>

- Name and address
- Date of injury
- Claim number
- Date of birth
- Other requested data

II. <u>Introduction</u>

- Explanations you give the worker about the purpose and procedures of the exam
- Statement about who accompanied the worker to the site
- Other pertinent data

III. <u>History from the worker</u>

Chief psychiatric complaint(s) or symptoms in the worker's own words

History of the present injury:

- How did the injury occur?
- How did the injury affect the psychiatric history?
- What has been the history of chronic pain, sexual abuse?
- What was life like at the time of injury?
- How did life change since the injury?

Current symptoms:

- What are the current symptoms?
- Have the symptoms changed over time?

Current Treatment

- What is the current treatment?
- Has there been failure to respond to treatments?
- If a physical injury, has there been a spread of symptoms to the adjacent areas?

Past psychiatric treatment

Family psychiatric treatment

Drug and alcohol history

Legal history

Trauma history

Worker's Compensation/work history

- What is the brief history of employment?
- What is the worker's relationship with the employer since the injury?
- What are the plans for return to work?
- Have there been prior vocational attempts?

Social history

- Childhood
- Education
- Relationships
- Occupation

Impact of the Injury (Socioeconomic history):

- Are there financial concerns?
- Are there limitations affecting activities?
- Has another family member had to assume additional responsibility?
- What education has the worker had?
- What is the worker's marital status?
- What is the worker's military experience?

Medical history

- What is the relevant childhood medical history?

IV. Record Review

It is important for you to conduct an accurate review of the worker's records prior to the exam.

Background records

- Pre-accident psychosocial functioning
- Pre-accident medical records
- Accident report (ROA): Helpful information includes description of injury, area of body injured, length of employment, and length of time between the injury and filing of the claim. Also review physician and employer portions.
- Immediate clinical findings at the time of the injury
- Early psychiatric complaints: Depending upon the nature of the injury, the presence of psychiatric findings immediately following the injury may suggest a preexisting condition.
- Past medical history: Review the histories of substance abuse, sexual abuse, chronic pain and any other relevant history.
- Psychological treatment: medical mental health or medical providers
- Non-physiologic medical findings

Psychiatric records

- Psychiatric treatment, including modalities and outcome
- Prior evaluations
- Other medical records which include social or psychiatric information

Psychiatric trauma claim

- Review investigation reports
- Survey employer information
- Review police reports

Vocational and physical therapy records

Review vocational and physical therapy records for the following:

- Attendance
- Compliance with recommendations
- Information about behavioral patterns
- Outcome of treatment

V. Report of the psychiatric examination

This report must contain data that support your diagnoses and conclusions. Use the current edition of the *Diagnostic and Statistical Manual of Mental Disorders (DSM)*. Include detailed information about symptoms pertinent to the diagnostic criteria for your diagnoses. Also if you have ruled out other doctors' diagnoses, then include the detailed information as to why your opinion differs.

Mental status exam

Current symptom profile
Include information about current activities, if you haven't already.

Substance abuse.
Address substance abuse, both current and prior. Also address prescription drug use, particularly opioids and other scheduled drugs.

Testing

Discuss results of any testing you have performed and provide copies of raw data.

Perform psychological testing, as indicated: Tests may include the Minnesota Multiphasic Personality Inventory (MMPI) or Beck Depression Inventory or others.

NOTE: Neuropsychological testing may be requested. Neuropsychological testing is not a standard part of a psychiatric IME. If you determine that a neuropsychological battery of tests is needed, contact the claim manager.

Conclusions

Diagnoses and findings: Follow the format of all five AXES of the current *Diagnostic and Statistical Manual of Mental Disorders (DSM)* to report your diagnosis. The diagnosis needs to meet DSM criteria for the specific disorder. Depending upon your preference, you may defer Axis III to other specialists. Discuss

your diagnoses for this case, including those findings that support your diagnoses. In a multi-examiner examination, review your diagnoses and recommendations with other examiners.

Causal relationship and preexisting condition:

- Is the condition diagnosed related to the injury?
- Are there preexisting conditions?
- Were they aggravated on a temporary basis?
- Were they aggravated on a permanent basis?

Treatment Recommendations:
Be complete.

If the injured worker has received psychiatric treatment as demonstrated in the psychiatric records and if you recommend additional treatment, explain the following:

- Why is additional treatment needed?
- How long will it take?
- Is this time needed to taper off treatment for the worker?
- Is this time needed to determine whether a new medication will be of benefit to the worker?
- What is the prognosis of this treatment?
- What is the prognosis for return to work?

If the injured worker has <u>not</u> received psychiatric treatment in this claim and if you are recommending treatment, explain the following:

- Why is treatment needed?
- How long will it take?
- Do you recommend medication?
- What barriers exist to prevent or delay successful treatment?
- What is the prognosis of this treatment?
- What is the prognosis for return to work?

Impairment rating, if appropriate:

- **Maximum Medical Improvement (MMI):** MMI is when an accepted condition has reached a fixed and stable condition, when it is reasonably certain that further medical treatment will not improve the illness or medical condition.
- **Diagnostic studies:** (summation)
- **Rating:** Use the Washington Category Rating System and state your diagnosis of the conditions you are rating. [WACs 296-20-330 and 296-20-340]
- **Rationale:** Your rationale for the rating is an important part of this report. Restate your objective observations and diagnosis.

Consult WACs 296-14-300 and 296-21-270 (Pages C 4-5) for more information on mental condition and mental disabilities. Other WAC references for Mental Health are contained on Pages V32-34.

Part Four: What if the claim manager asks me to address vocational issues?

Note: You must <u>only</u> address physical restrictions, job analyses, job modifications and other vocational issues, if specifically requested by the claim manager.

Clear information about the worker's physical or mental capacities is vital to include in your IME report. Please objectively describe those limitations that may be barriers to returning to work. We need this information in order to decide the vocational issues of a claim.

For administrative and legal reasons, we request that you not give opinions regarding transferable skills, education, or labor market, etc. A vocational professional does this assessment. We also request that you not make a direct statement that a person is totally and permanently disabled or a "pension." Vocational rehabilitation counselors and claim managers are required to rule return-to-work options in or out in a sequence delineated in law (RCW 51.32.095).

Never use the word "retraining" in your recommendation. The term "retraining" has a specific legal and administrative meaning that limits which workers are eligible for these services. You and the claim manager may not be using the same definition. A worker who hears your recommendation for "retraining" may become frustrated or angry if the claim manager cannot meet the worker's expectations. Good terms to

use instead of "retraining" are "vocational evaluation" or "vocational assessment." This usage will not establish false hopes for the worker and will alert the claim manager to unresolved vocational issues.

What if I have questions about job requirements (e.g., workplace modification or job analyses)?

Contact the person who requested the examination and state that you still have questions, even though you have reviewed the vocational information sent you. Ask to speak with a vocational consultant to help you review the job requirements. You can bill for your time spent in discussing the case with the vocational consultant. Consult the *Medical Aid Rules and Fee Schedules* for billing procedures: www.LNI.wa.govgov/claimsinsurance/providers/billing/.

Section III

If asked, how do I address physical capacities?

The IME report content described in Sample Report # 1 on Pages B 2-6 includes one element called "Physical Restrictions" which relates to vocational issues. Use the instructions below to answer questions about physical restrictions.

In assessing physical restrictions, consider the injury and any preexisting conditions. If the injury or exposure has led to unique limitations for the worker, you must state this clearly. If a worker has a preexisting unrelated condition that has progressed since the date of injury, you must clearly state this fact in your report. Specify what restrictions or limitations are due to the post-injury progression of the preexisting, unrelated condition. For example, a worker may be able to perform work at the medium level, considering an accepted knee injury, but the worker's preexisting unrelated cervical degenerative disc disease has progressed post-injury and cervical spinal stenosis is now limiting the worker to sedentary work.

If asked, you may find that one of the best ways to estimate restrictions is to use the Doctor's Estimate of Physical Capacities (PCE) form (see Page B 17). You may photocopy this page and fill one out for each worker you examine. If you prefer, you can specify restrictions in the body of your report. See Pages B 18-19 for a description of physical demands and environmental conditions.

State what conditions cause the restrictions. These conditions can include the following:

- Accepted conditions,
- Preexisting conditions and/or
- Conditions that occurred after the industrial injury.

For example, if a worker has an accepted back injury, he or she may be able to work at light work. The worker's cardiac condition, however, may prevent his or her return to work.

Differentiating between "permanent" and "temporary": If restrictions are temporary, label clearly. Also estimate how long the temporary restriction will last. For example, you might state: "Avoid heavy lifting for three months"; or "Increase activity level over the next six weeks." Keep **permanent** restrictions consistent with your medical examination. Any permanent restrictions should:

- Have a reasonable medical basis and
- Be based on diagnoses given in your report.

Sometimes you may not be able to address the work restrictions completely. If you can't, simply explain why or advise what information you need to help you address the restrictions. Here are some examples:

- You may not be able to predict the course of illness or recovery adequately.
- You may be evaluating the worker because of your special expertise in a particular body system. For example, an IME dentist may not have the expertise needed to give an opinion about ability to work.

At times the claim manager may request you review a performance-based physical capacities evaluation.

What is a job analysis and/or job descriptions?

You may be asked to review and approve job analyses (JAs) or job descriptions. These reports should provide detailed information regarding specific physical demands and environmental conditions required for a job.

A **job description** (sometimes may be a job offer) is a brief written description of a job by the employer that is available to the worker. The employer prepares the job description shortly after it is known that the worker will be off work. The job description is typically for the worker's job at the time of injury. It may also identify potential modifications to the job of injury and should include a summary of job duties/tasks, equipment and tools used, and a description of specific physical demands. Some job descriptions represent an alternative job available for the worker. Employers use no standard format. See the *Attending Doctor's Return-to-Work Desk Reference* for further information and differentiation between job description and job analysis. See #11 inside back cover to order a copy.

A **vocational rehabilitation counselor assigned by a claim manager, usually later in the claim, specifically develops a job analysis.** These job analyses typically appear similar to job descriptions and may be presented in a variety of formats, often on a Physical Demands Job Analysis form. It is a detailed

evaluation of a specific job or type of job.

The following list describes types of job analyses that you may be asked to review:

- The actual analysis of the worker's job of injury;
- Lighter duty or modified versions of the job of injury that the vocational counselor has negotiated with the employer;
- Other jobs the employer of injury may have available;
- Other jobs performed by the worker prior to the injury;
- Other jobs based on a worker's transferable skills from previous employment/training; or
- Jobs being considered for future training possibilities.

How do I review and respond to a job description or job analysis?

Review and report on job descriptions and job analyses (JA) in the same way.

You will usually be asked to review three or four job analyses, although more may be sent in complex cases. If you feel that you are being asked to review unnecessary job analyses, discuss your concerns with the claim manager who requested the IME.

During the review, please focus your attention only on the physical and/or mental demands of the job. Considering your specialty please answer the following question in your JA response: **"Can the patient physically and/or mentally perform the tasks as described?"** If not, state the objective evidence to support your conclusion.

Do not consider wages, personal issues, or employability.

When you sign the JA, you are approving the maximum physical requirements of the job—not the minimum.

Your conclusions about the worker's ability to perform physical demands must match between the JAs, Doctor's Estimate of Physical Capacity form (PCE), and any physical restrictions contained in your IME report. If you approve a medium level JA, this determination of the worker's maximum physical capacity must also be reflected in all of your reports and form. (See Sample form #7 in Appendix B.)

What information should I provide in the job analyses?

- State whether the worker can or cannot perform the physical demands of the job as described. Also state whether job modifications or accommodations may let the worker perform specific tasks or activities. A physical or occupational therapist or vocational rehabilitation counselor may make recommendations about **specific** job modifications.
- If you disapprove of a job analysis, but the restrictions are **temporary**, as the worker's capacities are likely to improve over time, note this fact in your report. Also give a time frame for when to get an updated review of the job analysis.
- State whether the accepted condition (individually or in combination with any preexisting conditions) allows for or prevents employment in the job described.
- List any preexisting conditions that are preventing employment.
- State whether a condition that occurred or progressed following the industrial injury prevents return to work.

How soon must I return the job analyses?

WAC rule states that job analyses sent to the IME provider at the time of the IME referral must be completed and submitted with the IME report. JAs' received within 60 calendar days after the IME must be reviewed, signed and sent to the department within 14 calendar days of receipt of the JAs [WAC 296-23-352].

If I feel job modification might be helpful, what should I do?

For more information on job modifications, see the *Attending Doctor's Return-to-Work Desk Reference* (#F200-002-000) and the *Attending Doctor's Handbook* (#F252-004-000). You may obtain copies of these publications by contacting an L&I Service Location or the L&I Warehouse at P.O. Box 44843, Olympia, WA 98504-4843, or you may order publications on line at www.LNI.wa.govgov/FormPublications.

You may also find job modification information in *Provider Bulletin* 99-11, which address "Job Modifications and Pre-job Modifications." You may access this Provider Bulletin on-line at www.LNI.wa.govgov/ClaimsInsurance/Providers/ProiderBulletins or call Provider Hotline at 1-800-848-0811.

The worker can also contact the U.S. Department of Labor's free Job Accommodation Network (1-800-526-7234) or on the web at www.jan.wvu.edu to explore various options for modifications to specific jobs.

Section IV:
Providing Testimony

What do I need to know about giving testimony?

When you sign the application to become an IME provider, you agree to perform exams and be available to testify. Payment for an IME compensates you for the detailed nature of your examination and report, as well as the complexity of the questions you must address, and your willingness to testify at some time in the future.

If you need to testify, you will be paid separately for these services. Discuss the fees with the party who requested that you provide testimony. Also see the Medical Aid Rules and Fee Schedules: www.LNI.wa.govgov/claimsinsurance/providers/billing/.

When performing the IME, you are determining clinical observations and conclusions in the claim at a point in time. All parties can then use this information. You may, therefore, be called as a witness for the worker, the employer, L&I, the self-insured employer or their representative, or by any combination of these.

IME providers must make themselves reasonably available to testify at the Board of Industrial Insurance Appeals or by deposition. You also agree to answer questions about the medical facts of the case at fees established under the authority of Washington's Industrial Insurance law. **Failure to comply with this requirement may result in termination of your IME provider number.**

If you are unwilling to testify, you must decline to perform examinations. Realize that only three to five percent of claims involving IMEs go before the Board of Industrial Insurance Appeals. Appearances before the Board are an important part of the services you provide to workers, employers and L&I.

Which is preferred – depositions or live testimony?

The Board prefers all witnesses, including doctors, to appear at hearings in person. They hold them throughout the state. Most attorneys will attempt to accommodate your schedule when arranging for your testimony. The Board has subpoena power to require your attendance if scheduling of testimony becomes too difficult.

You should obtain a copy of your IME report and review it prior to testimony. If you need any L&I records, contact the party who requested your service to have information sent. If you need more time for extensive record review, you should discuss this fact with the party who requested your service. **Please discuss cancellation and notice fees with the party who requests your services at the time your testimony is scheduled.**

Nine times out of ten, attorneys are able and willing to accommodate the examiner by taking the testimony by deposition. Depositions are allowed in every instance unless expressly precluded by the Board. If the worker is present, then the examiner's deposition is routinely prohibited. It is often more persuasive for an Industrial Insurance Appeals Judge to hear testimony "live," as opposed to reading the transcript of a deposition.

What is the appeals process?

The table on the following page presents an overview of the appeals process, from the Board of Industrial Insurance Appeals to the Washington State Supreme Court. The information will help you understand some of the legal processes that affect your work in the industrial insurance system. Your involvement is most likely to be with the Board of Industrial Insurance Appeals.

For more information about the Board call 360-753-6823 or www.biia.wa.gov.

L&I APPEALS PROCESS OVERVIEW

Level of Appeal	What Can be Appealed to this Tribunal?	What types of Information Are Considered on this Appeal?	What Are the Possible Outcomes?
Board of Industrial Insurance Appeals	All department decisions, awards, and orders issued by the department can be appealed to the Board.	Both parties introduce evidence relevant to the appeal. This includes depositions or in-person testimony of medical and lay witnesses. The Board does not receive the Department claim file, but parties may introduce information from the file as evidence.	The Board will issue an order accepting or denying the appeal. The appealing party may voluntarily dismiss the appeal, or the parties may settle the case. If the case proceeds to hearing, the Industrial Appeals Judge will issue a proposed order either affirming, reversing or modifying the Department order. This order will become a final order if not appealed. Either party may appeal the proposed order. In that case, the Board will review it, and issue a final order.
Superior Court	Employer and worker may appeal any Board order to the Superior Court. The Department may appeal only issues of law.	The record created at the Board, including transcripts of testimony, will be read to the court. No new testimony or exhibits are permitted.	The Superior Court will affirm or reverse the Board order.
Court of Appeals	Only questions of law may be taken to the Court of Appeals.	The Court of Appeals considers the same evidence as the Supreme Court.	The Court of Appeals may affirm, reverse, or modify the Superior Court order. A published decision (that is not appealed to the Supreme Court) creates case law that must be followed by Washington Superior Courts and administrative tribunals.
Supreme Court	The Supreme Court will consider appeals, generally from the Court of Appeals, and determine whether to review them.	The Supreme Court considers the same evidence as the Court of Appeals.	The Supreme Court may affirm, reverse or modify the Court of Appeals decision. Supreme Court decisions create case law that must be followed by all Washington courts and administrative tribunals.

Section V:

Impairment Rating

Part One: What do I need to know about rating impairment?

What is the difference between "impairment" and "disability," and why is this important?

"Impairment" is the loss of function of an organ or part of the body. See WAC 296-20-200 (4) for a further detailed description. "Disability" means the inability to perform a specific task or job.

For example, if a classical pianist and a truck driver both lose the same finger, both have the same impairment and receive the same award amount. However, their disabilities may be different: the truck driver may be able to continue performing the job, while the pianist may not.

This distinction is important because state law requires that awards be based on impairment, not on disability.

Is an IME the same as an impairment rating examination?

No. IMEs and impairment rating exams are not synonymous. A rating exam may be part of an IME or a consultation. It may also be part of a routine office visit to the attending doctor. The department or self-insurer may request an IME for various reasons. (See Page I-1.) Most IMEs do contain impairment ratings.

IMEs establish medical facts about an injured worker's physical and/or mental condition so that the department or self-insurer can give appropriate assistance to the worker and can make fair administrative decisions about the claim.

Who may rate an impairment?

IME examiners: Any doctor who is an L&I-approved IME examiner may do rating exams as part of an IME if requested by the claim manager. Ratings by IME examiners must be accompanied by an IME report described in **Appendix B**, **Sample Report 1**. If you are asked to perform a "rating only IME," use **Sample Report 2**.

Attending doctors: Attending doctors may be asked by the claim manager to rate impairment for their own patients. Rating reports (see **Appendix B**, **Sample Report 3**) are shorter than IME reports, since ratings are just one of many elements in an IME.

Doctors licensed in medicine and surgery, osteopathic medicine and surgery, podiatric medicine and surgery, and dentistry may conduct these exams on their own patients. Chiropractors who are approved IME examiners may also conduct these exams on their own patients if requested by a claim manager (WAC 296-20-0210).

If the attending doctor does not wish to rate his/her own patient, the department encourages him/her to ask a consultant to perform the rating exam. (See "Consultants" in the next paragraph.) In the terminology of the department, consultations are different from IMEs. One difference is that the examiner in an IME is generally chosen by the department or self-insured employer, while a consultant is generally chosen by the attending doctor.

If you need assistance in selecting a consulting doctor, names of approved IME examiners may be found on the web at www.IMEs.LNI.wa.gov. If more than one specialty is needed to evaluate the impairment, notify the claim manager so the option of an IME can be considered.

Consultants for rating impairment: Consultants must be familiar with the *Medical Examiner's Handbook* and follow its standards and guidelines and provide an IME rating report as described in **Appendix B**, **Sample Report 2**. Doctors performing consultations involving a rating of permanent impairment may use the billing codes for consultant ratings. If you are a consultant and become an approved IME examiner, you do NOT need to be affiliated with an IME panel, and you are NOT obligated to accept referrals for IMEs.

Limited license providers: Limited license providers (for example, dentists, podiatrists, and chiropractors) may only provide ratings for regions or conditions within their scope of practice. Chiropractors must be approved IME examiners.

When do I rate an impairment?

When the worker's industrial injury or disease has reached maximum medical improvement (fixed and stable), the claim manager may ask you to rate the accepted condition. If the worker's condition is not at MMI, the worker's impairment should not be rated (unless you have special instructions from the claim manager). Please see Page III-3 for the definition of MMI.

What are the five required components of ALL impairment reports?

Depending on the circumstances, an impairment rating may be performed by an attending doctor, an IME examiner or a consultant. In the context of an IME, the rating is often just one of many elements of a full IME report. When performed by an attending doctor, the rating report may be a stand-alone report or may be part of a chart note, a closing report or other types of reports.

Regardless of who performs it, reports on impairment rating MUST contain ALL of the following five sections:

1. **MMI:** A statement that the patient has reached maximum medical improvement (MMI) and that no further curative treatment is recommended
2. **Examination:** Pertinent details of the physical or psychiatric examination performed (both positive and negative findings)
3. **Diagnostic tests:** Pertinent results of any diagnostic tests performed (both positive and negative). Include copies of pertinent tests ordered as part of the exam.
4. **Rating:** An impairment rating consistent with the findings and a statement of the system on which the rating was based (e.g., Washington State Category Rating System, the AMA *Guides*, etc.)
5. **Rationale:** The rationale for the rating system is one of the most important parts of the rating report. The rationale must be supported by specific references to the clinical findings, especially objective findings and supporting documentation, including the specific rating system, tables, figures and page numbers on which the rating was based. The rationale must restate all objective findings. [WAC 296-20-2010 & WAC 296-23-377]

How important is medical judgment in the rating process?

Most of the information in this handbook constitutes guidelines on how to rate impairment. Guidelines are NOT hard and fast rules. Sound medical judgment plays an important part in the process of rating impairment. Both the Category Rating System and the American Medical Association *Guides to the Evaluation of Permanent Impairment* (the two rating systems most commonly used in Washington state workers' compensation) emphasize the importance of medical judgment in this area.

At the same time, you should base your conclusions on objective findings, and you should state your rationale clearly.

How should objective findings be used in the rating process for physical and psychiatric impairment?

An impairment rating must be supported at least in part by objective findings (*Cooper v. Department, 1944*). Objective findings are those findings on examination that are "independent of voluntary action and can be seen, felt, or consistently measured by examiners" (WAC 296-20-220[i]). However, psychiatric impairments do not require the same extent of objective findings as do physical injuries (*Price v. Department, 1984*) – see Pages V 32-34, III 7-9 for details on a psychiatric IME report.

What rating systems should I use?

Four rating systems are generally used to rate impairment in Washington State Workers' Compensation. The use of these four systems is restricted to certain conditions by law, as described below and summarized in Table 2 based on WAC 296-20-2015.

Injuries before 1974 and conditions not otherwise addressed are dealt with differently (see Pages V-4). You should also be aware of special considerations regarding impairment due to pain (see Pages V-4).

Table 2:
Overview of Systems for Rating Impairment

Rating System	Used for these Conditions	Form of the Rating
1. **Category Rating System (Washington State)**	Spine, neurologic system, mental health, respiratory, taste & smell, speech, skin, and disorders affecting other internal organs	Select the category that most accurately indicates overall impairment
2. **AMA *Guides***	Loss of function of extremities, partial loss of vision and hearing	Determine the percentage of loss of function, as compared to amputation value listed in RCW 51.32.080
3. **RCW 51.32.080 (see page V3)**	Specified disabilities: loss by amputation, total loss of vision and hearing	Supply the level of amputation or total loss
4. **Total Bodily Impairment (TBI)**	Impairments not addressed by any of the rating systems above	Supply the percentage of TBI. **(Note: This is an unusual situation.)**

1. Washington State Category Rating System.

To rate impairment resulting from back disorders, psychiatric disorders, neurologic disorders, respiratory disorders and other disorders affecting the internal organs, you **must use** the Washington State Category Rating System. The intent of the Category Rating System is to reduce litigation and to establish more uniformity in the rating of unspecified permanent partial impairment. The category rules do not allow you to express a rating as a percentage.

Section V, Part 2, page V-7, presents details about

the Category Rating System for the spine, respiratory system, and all other systems included. For most body systems, the Category Rating System is expected to be self-explanatory. Since the creation of the Category Rating System in 1974, doctors have been expected to read the statutes and regulations (RCWs and WACs) and figure out the rating on their own. Here are a few points that may help to understand how to use this system:

Flexibility of the Category Rating System: In many cases, there are bound to be reasonable differences in how clinicians interpret findings. Sound medical judgment will play an important role. Doctors should understand that there is considerable flexibility in the Category Rating System. It is not necessary for doctors to be unduly rigid in interpreting the regulations (WACs) or the guidelines presented in this guide.

If the worker seems to fit more than one category: The department recognizes there are situations where a patient's findings may be found in more than one category. In such a case, the doctor should select the ONE category which most closely describes the patient's condition. The doctor SHOULD NOT "split" categories. For example, the doctor should NOT give a rating of Category 2.5 if the patient seems to be between a Category 2 and a Category 3. Medical judgment should be used to select the best category, as described above. For rating cervico-dorsal, dorso-lumbar and lumbo-sacral impairment, you may find it helpful to use the worksheets provided on Pages V-9, V-19.

RCWs and WACs: Doctors who are interested in having a detailed understanding of the Category Rating System may wish to read the full text of the statutes and regulations pertaining to this topic (see Appendix C).

2. American Medical Association *Guides to the Evaluation of Permanent Impairment (AMA Guides).*

If the injury or occupational disease is not included in the Category Rating System and is not an amputation or total loss of vision or hearing (as described in #3, "RCW 51.32.080" below), then you rate the impairment as a percentage, using the most recent edition of the AMA *Guides*.

Washington State has specific rules for Washington state workers' compensation regarding the use of AMA *Guides*. For example, you should be familiar with the WACs and other information included in P*rovider Bulletin 02-12: Rating Permanent Impairment*. That Provider Bulletin deals with a number of issues, including the question "To what extent is pain considered in an award for permanent partial disability?" This issue is now addressed in WAC 296-20-19030. Similarly, you must be familiar with proper use of the AMA *Guides* for rating extremities, vision and hearing, so you must carefully read all sections of this handbook pertaining to impairment rating, including but not limited to Section V, pages V 7-42. The AMA *Guides* is available from the Order Department, American Medical Association, PO Box 109050, Chicago, Illinois 60610-9050; 1-800-621-8335 or 312-464-5651.

3. RCW 51.32.080.

This system is used for disabilities specified in RCW 51.32.080, namely: loss by amputation; loss of one eye by enucleation; loss of central visual acuity in one eye; complete loss of hearing in both ears; complete loss of hearing in one ear. For these impairments, rate by indicating the disability specified in RCW 51.32.080 it most closely resembles or approximates in degree of disability. The term "specified disabilities" refers to disabilities that are listed in that RCW.

4. Rating other impairments.

There are unusual circumstances in which the rating may need to be stated as a percentage of total bodily impairmant. The AMA's *Guides* may be a helpful reference in making this determination.

Table 3: WHICH RATING SYSTEM TO USE
(for claims with date of injury after October 1, 1974)

ORGAN SYSTEM, BODY PART OR TYPE OF INJURY	RATING SYSTEM	SEE PAGE IN THIS BOOK:
Amputation	Specified in RCW	V 28-30
Back (Cervical, Thoracic, Lumbo-Sacral)	Category Rating System	V 7-25
Cardiac	Category Rating System	V 26
Cognitive Impairment	AMA *Guides*	V 34
Convulsive Neurologic Disorders	Category Rating System	V 26
Digestive Tract	Category Rating System	V 26-27
Extremities	AMA *Guides*	V 28-29
Hearing		
* Total loss	Specified in RCW	V 30
* Partial loss	AMA *Guides*	V 30-33
Mental Health	Category Rating System	V 34-36
Pelvis	Category Rating System	V 36
Respiratory	Category Rating System	V 36-41
* Air Passages	Category Rating System	V 36
* Chronic Sinusitis	AMA *Guides*	V 41
Skin	Category Rating System	V 41-42
Speech	Category Rating System	V 42
Taste and Smell	Category Rating System	V 42
Urologic	Category Rating System	V 43-44
Visual System		
* Enucleation	Specified in RCW	V 44
* Total loss	Specified in RCW	V 44
* Partial loss	AMA *Guides*	V 44
Others not listed above	Total bodily impairment	

How are injuries prior to October 1974 handled?

Injuries between 1971 and 1974: Injuries or exposure occurring on or after July 1, 1971, but before October 1, 1974, are rated as a percentage of total bodily impairment, but do not use the Category Rating System. The examination request letter will ask you to "express your rating as a percentage of total bodily impairment."

The percentage rating that you provide should reflect how the impairment affects the function of the person, as a whole, in the ordinary pursuits of life. This is described as a percentage of total bodily impairment. The most current edition of the AMA *Guides* may be helpful in making this determination.

Injuries prior to 1971: For an injury or exposure that occurred prior to July 1, 1971, you should rate impairments to extremities, hearing loss and vision impairment in terms of percentage of loss of function of that area of the body. Use the most current edition of the AMA *Guides* to rate theses impairments.

For all other impairments, rate by indicating the specified disability it most closely resembles or approximates in degree of disability. The term "specified disabilities" refers to disabilities that are listed in RCW 51.32.080. The Category Rating System should not be used, as it applies only to Washington claims on or after October 1, 1974. Again, please use the most current edition of the AMA *Guides* to rate these impairments.

How is pain considered in an impairment rating?

WAC 296-20-19030
To what extent is pain considered in an award for permanent partial disability?

The categories used to rate unspecified disabilities incorporate the worker's subjective complaints. Similarly, the organ and body system ratings in the AMA Guides to the Evaluation of Permanent Impairment incorporate the worker's subjective complaints. A worker's subjective complaints or symptoms, such as a report of pain, cannot be objectively validated or measured. There is no valid, reliable or consistent means to segregate the worker's subjective complaints of pain from the pain already rated and compensated for in the conventional rating methods. When rating a worker's permanent partial disability, reliance is primarily placed on objective physical or clinical findings that are independent of voluntary action by the worker and can be seen, felt or consistently measured by examiners. No additional permanent partial disability award will be made beyond what is already allowed in the categories and in the organ and body system ratings in the AMA guides.

For example:

- Chapter 18 of the 5th Edition of the AMA *Guides to the Evaluation of Permanent Impairment* attempts to rate impairment caused by a patient's pain complaints. The impairment caused by the worker's pain complaints is already taken into consideration in the categories and in the organ and body system ratings in the AMA guides. There is no reliable means to segregate the pain already rated and compensated from the pain impairment that Chapter 18 purports to rate. Chapter 18 of the 5th Edition of the Guides to the Evaluation of Permanent Impairment cannot be used to calculate awards for permanent partial disability under Washington's Industrial Insurance Act.

Does the rating process include consideration of the worker's financial need?

Industrial insurance law determines disability payments to the worker on the basis of the amount of impairment. You are not asked to consider the worker's financial situation. For example, a worker with a knee injury who owns two homes and a boat will receive the same award as a worker with a similar knee injury who is in financial need. Social Security Disability, a federal program, is available to disabled workers who have contributed to the Social Security trust fund. Supplemental Security Income is available to permanently disabled people. If appropriate, you may recommend that the attending doctor assist the worker in exploring these resources, and your examination may be used as part of the medical evidence to establish eligibility. The worker can be referred to the Social Security Administration at 1-800-772-1213.

How do I deal with preexisting conditions and segregation?

Industrial insurance law recognizes that not all workers are in perfect physical condition before their injury or exposure. Sometimes an industrial injury or occupational exposure can exacerbate a preexisting medical problem. Sometimes a preexisting condition can change independently of an industrial injury or occupational exposure.

Aggravation (also referred to as "worsening" or "exacerbation"—the three terms are used synonymously in Washington workers' compensation) of a preexisting condition occurs when an injured worker has a preexisting condition, symptomatic or asymptomatic, which is made worse by the industrial incident or exposure.

Your role, as an examiner, is to provide documentation of clinical observations and conclusions, so that the law can be applied correctly. Here are four examples of situations you might face:

- A worker may have had a condition that was asymptomatic and non-disabling, and then the injury or occupational disease caused the condition to become a problem for the worker.
- A worker may have an injury or contract an occupational disease that accelerates a preexisting symptomatic or disabling condition, or causes it to become worse.
- A worker may have an underlying condition that was temporarily affected by an injury or occupational disease, and now has returned to pre-injury status.
- A worker may have a preexisting condition which is not affected by an injury or occupational disease.

The department and self-insured employers apply two legal concepts in cases of preexisting conditions: **lighting up and segregation**. When these legal concepts are applied, we know if we are to accept full responsibility for a preexisting condition, partial or limited responsibility for the preexisting condition, or to deny responsibility for the preexisting condition. Whether a condition has been "lighted up" or needs to be "segregated" is a legal determination made by the department. In order to make this determination, we need your best medical judgment of the worker's condition before and after the industrial injury, and whether the industrial injury "lighted up," aggravated (permanently or temporarily) the condition, or whether the condition is totally unrelated to the industrial injury.

When does L&I accept full responsibility for a preexisting condition? "Lighting Up"

If an injury activates a previously asymptomatic AND non-disabling condition, the entire resulting impairment is attributed to the injury rather than to the preexisting condition. The law allows compensation for preexisting asymptomatic conditions made symptomatic or "lighted up," by the industrial injury. This principle was established by the legal case of *Miller v. the Department* (1939). When the department or self-insured employer has accepted the full effects of a preexisting condition, the doctor should NOT make any determination regarding segregation of preexisting impairment when completing a rating examination. (See Sample Report #4, page B-9)

When does L&I accept limited responsibility for a preexisting condition? "Segregation"

When medical evidence discloses that a preexisting condition was disabling and symptomatic prior to the injury, our responsibility is limited to the increase in impairment due to the industrial injury. We must segregate (subtract) the prior impairment from the overall impairment. In these cases, the doctor needs to advise us both of the impairment due to the industrial injury and of the preexisting impairment. There are no hard and fast rules about how to determine prior impairment. In many cases the apportionment must rely on the doctor's best medical opinion, (for example, in cases where no x-rays were obtained prior to the injury.) In some cases, the doctor may have a long-standing relationship with the patient and may have detailed medical records which allow a fairly accurate estimate of prior impairment (see Sample Report #5, Page B-10). In some cases, the claim manager may be able to provide records to which the attending doctor does not have easy access. In any case, the expectation of the examining doctor is simply to make the best determination possible, and to provide a brief explanation of the basis for that determination.

When does L&I deny responsibility for a preexisting condition?

When a condition is totally unrelated to the industrial injury or occupational exposure, or if the worker has a preexisting condition and medical evidence does not establish that the condition was aggravated by the industrial injury or exposure, L&I may deny responsibility for the preexisting condition. In addition, we are not responsible for the natural progression of the preexisting condition or for changes due to the natural aging process. **In these cases, we may ask you to estimate the percentage due to the industrial injury.**

What should I do to address preexisting conditions?

To summarize, when L&I has accepted the full effects of a preexisting condition, the doctor should NOT make any determination regarding segregation of preexisting impairment when completing a rating examination. If you believe that the preexisting condition was symptomatic AND disabling prior to the worker's injury, you should:

1) Rate the impairment that existed prior to the worker's injury; and
2) Document the basis for your opinion. At a minimum this should include the following:
   - A discussion concerning how often the condition was symptomatic prior to the injury;
   - The last time the condition was symptomatic prior to the injury;
   - Any treatment the worker received for the condition prior to the injury (including the use of over-the-counter medications);

- A synopsis of prior medical records and diagnostic studies;
- The effect, if any, of the preexisting condition on the worker's daily activities/lifestyle prior to the injury (for example, did the worker miss time from work, require bed rest, need to refrain from performing certain household activities, etc.); and
- Any prior impairment award which the worker received for the condition.

Where can I find more information about occupational diseases?

Refer to Pages III 5-6 for information about occupational diseases.

Who gives authorization for diagnostic tests?

See Page II-5 for discussion of diagnostic testing, (same as for IME)

Where can I get further assistance?

If you have questions about which rating system to use or have other technical rating questions, contact the L&I Provider Review and Education Unit. See #8 inside of back cover for contact information.

Who provides an interpreter?

See Page II 3 for discussion of use of interpreters (same as for IME). See also WAC 296-20-2025.

Who is allowed to attend an impairment rating?

See Pages II 3-4 for discussion of persons allowed in the impairment rating (same as for IME).

May the worker record the impairment rating exam?

See Page II 4 for discussion of recording devices (same as for IME).

How do I get training to do Impairment Rating Exams?

See pages II 2-3 for training information.

PART TWO: What are the detailed instructions for rating the various body systems?

This section should be used in conjunction with Section V-1, which gives general instructions on how to rate impairment. Also, please refer to Page V-3 in that section for Table 3, which summarizes where to look for the appropriate rating system for a given condition or diagnosis. Please note: The regulations (WACs) cited here are specific to the body systems. You can find other WACs relating to IMEs and rating impairment in Appendix C.

Body Systems

Back Impairment

Cervical and Lumbo-Sacral Worksheets, Guidelines, Case Examples, Sample Reports

For most organ systems, the Category Rating System is expected to be self-explanatory. Since the creation of the Category Rating System in 1974, doctors have been expected to read the statutes and regulations and figure out the rating on their own.

The department has developed tools to improve the consistency, fairness, and "user-friendliness" of the Category Rating System.

Use of these tools is NOT required. Doctors are encouraged to use these tools as they deem appropriate. These tools are NOT hard and fast rules. They are intended to offer guidance. As always, sound medical judgment should be used in application of these materials. If you prefer to refer directly to the WACs, see Pages V-8.

These tools are:	Found on
• The "Doctor's Worksheet for Rating Cervical and Cervico-Dorsal Impairment"	Pages V 9-11
• The "Doctor's Worksheet for Rating Dorso-Lumbar and Lumbo-Sacral Impairment"	Pages V 19-21
• The "Guidelines for Interpretation of the Category Rating System for Cervical and Cervico-Dorsal Impairment"	Pages V-12
• The "Guidelines for Interpretation of the Category Rating System for Dorso-Lumbar and Lumbo-Sacral Impairment"	Pages V-18
• Case examples of cervico-dorsal impairment	Pages V 13-15
• Case examples of lumbo-sacral impairment	Pages V 22-24
• Instructions on use of the WACs, with sample reports and statement of general principles	Pages V 25-42

Section V

A. Cervical and Cervico-Dorsal Spine

General Principles

Several general principles should be followed when rating cervical and cervico-dorsal impairment. These include the following:

- **Bladder and/or bowel sphincter impairments**: Objectively demonstrated bladder and/or bowel sphincter impairments must be evaluated separately, using the Washington State Category Rating System. See "Urologic" and "Digestive Tract" sections.
- **Discectomy and fusion**: Discectomy and fusion should only be considered in rating impairment to the extent that they produce cervical or cervico-dorsal impairment.
- **Worksheet**: Examiners may find it helpful to refer to the worksheet, guidelines and case examples on Pages V-9 to V-15.

Rules (WAC 296-20-230)

1. Rules for evaluation of cervical and cervico-dorsal impairments are as follows:
   (a) Muscle spasm or involuntary guarding, bony or fibrous fusion, any arthritic condition, internal fixation devices or other physical finding shall be considered in selecting the appropriate category, only insofar as productive of cervical or cervico-dorsal impairment.
   (b) Gradations of clinical findings of cervico-dorsal impairments in terms of "mild", "moderate" or "marked" shall be based on objective medical tests.
   (c) Categories 2, 3, 4 and 5 include the presence of complaints of whatever degree in the neck or extremities.
   (d) Bladder and/or bowel sphincter impairments deriving from cervical and cervico-dorsal impairment shall be evaluated separately.
   (e) Neck as used in these rules and categories shall include the cervical and adjacent areas.

Categories (WAC 296-20-240)

Choose the category below which best describes the patient's impairment:

Category 1. No objective clinical findings are present. Subjective complaints may be present or absent.

Category 2. Mild cervico-dorsal impairment, with objective clinical findings of such impairment with neck rigidity substantiated by x-ray findings of loss of anterior curve, without significant objective neurological findings.

- This and subsequent categories include the presence or absence of pain locally and/or radiating into an extremity or extremities.
- This and subsequent categories also include the presence or absence of reflex and/or sensory losses.
- This and subsequent categories also include objectively demonstrable herniation of a cervical intervertebral disc with or without discectomy and/or fusion, if present.

Category 3. Mild cervico-dorsal impairment, with objective clinical findings of such impairment, with neck rigidity substantiated by x-ray findings of loss of anterior curve, narrowed intervertebral disc spaces and/or osteoarthritic lipping of vertebral margins, with significant objective findings of mild nerve root involvement.

- These and subsequent categories include the presence or absence of any other neurological deficits not otherwise specified in these categories with the exception of bladder and/or bowel sphincter impairments.

Category 4. Moderate cervico-dorsal impairment, with objective clinical findings of such impairment, with neck rigidity substantiated by x-ray findings of loss of anterior curve, narrowed intervertebral disc spaces and/or osteoarthritic lipping of vertebral margins, with objective findings of moderate nerve root involvement with weakness and numbness in one or both upper extremities.

Category 5. Marked cervico-dorsal impairment, with marked objective clinical findings of such impairment, with neck rigidity substantiated by x-ray findings of loss of anterior curve, narrowed intervertebral disc spaces and/or osteoarthritic lipping of vertebral margins, with objective findings of marked nerve root involvement with weakness and numbness in one or both upper extremities.

Doctor's Worksheet for Rating Cervical and Cervico-Dorsal Impairment

Instructions:

To improve consistency, fairness and "user-friendliness," a worksheet has been developed through a cooperative effort with input from representatives of the medical, osteopathic, and chiropractic communities, along with input from representatives of business, labor, and the legal community.

- The worksheet serves as the rating report (when it is filled out completely, signed and dated by the doctor).

Attending Doctors: This worksheet is all you need to send to the claim manager if you are the attending doctor (assuming that you have provided all the required documentation - chart notes, history and physical, etc.). Please attach a separate note to provide additional detail when appropriate. For example, it can be important to the claimant if there is a worsening of the condition and a re-opening application is filed. In such cases, details about the findings at the time of the impairment rating will generally be needed to compare with the findings at the time of application to re-open the claim.

IME examiners and consultants: You should attach the worksheet to the full IME report as described on page III-1.

- Caution **regarding SEVERE impairment:** This worksheet is NOT designed for the rare patient with severe impairment such as patient's long tract signs. For a patient such as this, you should refer to the WACs on page V-8, along with general information on impairment rating in other sections of this handbook.
- Caution **regarding PREEXISTING conditions:** As with any impairment rating, examiners should be familiar with procedures when a claimant has preexisting conditions. Please refer to Pages V 4-6 of this handbook for details.
- Bladder and/or bowel sphincter impairment: Objectively demonstrated bladder and/or bowel sphincter impairments must be evaluated separately. See "Digestive Tract" and "Urologic" sections. This impairment should be reported by attaching a separate page to the worksheet. (Be sure to put the patient's name and claim number on every page of all attachments in case they become separated from the worksheet.)
- The worksheet should be used in conjunction with the WACs. You should read and be familiar with the WACs on Page V 8. You may also find it helpful to use the guidelines on Page V 12 and the case examples on Pages V 13-14.

Why was the worksheet designed this way?: You may wonder why the Worksheet and Guidelines were designed the way they were. Part of the explanation is that both tools must, of necessity, be consistent with the Category Rating System. They do not, and cannot, replace the Category Rating System. The Category Rating System is established in the Washington Administrative Code (WAC).

The worksheet, along with a SAMPLE worksheet filled out for a case example, are included on the following pages. Please feel free to photocopy the worksheet.

Use of the worksheet is NOT required. You are encouraged to use it as you deem appropriate. These tools are NOT hard and fast rules. They are intended to offer guidance. As always, sound medical judgment should be used in application of these materials. If you prefer to refer directly to the WAC, see Page V-8.

Example

Mr. Y, a 45 year old male, has a six-month history of neck pain with parathesias globally from the elbow distally in the left upper extremity. Treatment included physical therapy and epidural steroid injections. Reflex, sensation and motor exams were within normal limits. Foramina compression test was positive on the left. Cervical range-of-motion was within normal limits. MRI showed mild circumferential disc bulges at C 5-6 and C 6-7. X-rays showed reversal of the cervical lordotic curve.

A	B	C
Nerve Root Involvement *(See Notes below.)*	**Neck Rigidity Substantiated by Imaging** *(Only include findings which are consistent with the clinical picture. Age related changes may not be significant in some cases --- see Notes.)*	**Range-of-Motion, Spasm, and Other Findings** *(Describe briefly in space below-- see Notes.)*
Circle one	**Circle one**	**Circle one**
none **(1)**	none **(1)**	none **(1)**
Decrease in reflexes; mild sensory loss; and/or root tension and compression signs (e.g., foramina compression test, etc.) (2)	Loss of anterior curve; and/or herniation at one level (2)	Mild (2)
		Moderate (3)
Mild weakness and sensory loss in one or both extremeties (3)	Mildly narrowed disc spaces; mild osteoarthritic lipping of vertebral margins; herniation at more than one level; and/or findings from discectomy or fusion (one level) indicative of siginficant neck rigidity. (3)	Marked (4)
		Describe ROM, spasm, etc. here: **Normal ROM**
Moderate distal weakness and sensory loss in one or both upper extremities. (4)	Moderately narrowed disc spaces; moderate lipping of vertebral margins; and/or findings from discectomy or fusion (more than one level) indicative of significant neck rigidity. (4)	
Marked distal weakness; moderate or marked proximal weakness; and marked sensory loss in one or both extremities (5)	Markedly narrowed disc spaces and/or osteoarthritic lipping (5)	

Step 4: Calculate Rating *(If you want L&I to do the calculation, copy the numbers into the 1st 3 boxes and go to Step 5.)*

Box number circled in Column A:	**2**
Box number circled in Column B:	**1**
Box number circled in Column C:	**1**
Total	**4**
Average (total divided by 3)	**1 1/3**
Enter the average rounded to nearest whole number (1.1=1, 1.5=2, etc.) This is the rating:	**1**

NOTES:

Column A: **Mild Weakness** = 4/5 (Complete motion against gravity and less than full resistance);
Moderate = 3/5 (Barely complete motion against gravity);
Marked = 2/5 - 0/5 (Complete motion with gravity eliminated to no evidence of contractility).
If lower extremities are involved (e.g., paraparesis), consult the *Medical Examiners' Handbook.*

Column C: Only include findings which are consistent with the clinical picture. NOT TO BE CONSIDERED: OSWESTRY OR OTHER PAIN SCALES. Pain is considered in the rating, but must be reflected in findings described on this worksheet (for example, decreased range of mothon). Bladder and bowel sphincter impairment should be rated separately.

Step 5: Certification

I certify that I have examined the patient within the last 8 weeks and that the above report truly and correctly sets forth my findings and opinion.

Doctor's address	ZIP+4	Provider No.
123 Maple Dr. Seattle, WA 98xxx-xxxx		**12345**

Print Dr's name	Today's date	Doctor's signature
John Smith M.D.	**3/1/05**	*John Smith M.D.*

The Physician should photocopy this worksheet for their medical records. Doctors should refer to the Medical Examiner's Handbook for instructions on the use of this worksheet.

F252-056-000 worksheet/cervical & cervico-dorsal 5-05

Department of Labor and Industries

Doctor's Worksheet for Rating Cervical and Cervico-Dorsal Impairment

Claimant's name | Claim #

Step 1: (a) Has the worker's condition reached maximum medical improvement? ☐ Yes ☐ No If no, do not rate. Please provide treatment recommendations.
(b) If there is a pre-existing condition, was it permanently aggravated by the industrial injury? ☐ Yes ☐ No If yes, attach explanation.

Step 2: Is there any permanent impairment? ☐ Yes ☐ No

Step 3: Circle one box in each column A through C below. Give brief explanation below (REQUIRED). Your entries should reflect the patient's current condition, as is including findings which may pre-date the injury. (See examples on page 2 of this worksheet)

A	B	C
Nerve Root Involvement *(See Notes below.)*	**Neck Rigidity Substantiated by Imaging** *(Only include findings which are consistent with the clinical picture. Age related changes may not be significant in some cases --- see Notes.)*	**Range-of-Motion, Spasm, and Other Findings** *(Describe briefly in space below-- see Notes.)*
Circle one	**Circle one**	**Circle one**
none **(1)**	none **(1)**	none **(1)**
Decrease in reflexes; mild sensory loss; and/or root tension and compression signs (e.g., foramina compression test, etc.) (2)	Loss of anterior curve; and/or herniation at one level (2)	Mild (2)
		Moderate (3)
Mild weakness and sensory loss in one or both extremeties (3)	Mildly narrowed disc spaces; mild osteoarthritic lipping of vertebral margins; herniation at more than one level; and/or findings from discectomy or fusion (one level) indicative of siginficant neck rigidity. (3)	Marked (4)
		Describe ROM, spasm, etc. here:
Moderate distal weakness and sensory loss in one or both upper extremities. (4)	Moderately narrowed disc spaces; moderate lipping of vertebral margins; and/or findings from discectomy or fusion (more than one level) indicative of significant neck rigidity. (4)	
Marked distal weakness; moderate or marked proximal weakness; and marked sensory loss in one or both extremities (5)	Markedly narrowed disc spaces and/or osteoarthritic lipping (5)	

Step 4: Calculate Rating *(If you want L&I to do the calculation, copy the numbers into the 1st 3 boxes and go to Step 5.)*

Box number circled in Column A:	
Box number circled in Column B:	
Box number circled in Column C:	
Total	
Average (total divided by 3)	
Enter the average rounded to nearest whole number (1.1=1, 1.5=2, etc.) This is the rating:	

NOTES:

Column A: **Mild Weakness** = 4/5 (Complete motion against gravity and less than full resistance);
Moderate = 3/5 (Barely complete motion against gravity);
Marked = 2/5 - 0/5 (Complete motion with gravity eliminated to no evidence of contractility).
If lower extremities are involved (e.g., paraparesis), consult the *Medical Examiners' Handbook.*

Column C: Only include findings which are consistent with the clinical picture. NOT TO BE CONSIDERED: OSWESTRY OR OTHER PAIN SCALES. Pain is considered in the rating, but must be reflected in findings described on this worksheet (for example, decreased range of mothon). Bladder and bowel sphincter impairment should be rated separately.

Step 5: Certification

I certify that I have examined the patient within the last 8 weeks and that the above report truly and correctly sets forth my findings and opinion.

Doctor's address	ZIP+4	Provider No.
Print Dr's name	Today's date	Doctor's signature

The Physician should photocopy this worksheet for their medical records. Doctors should refer to the Medical Examiner's Handbook for instructions on the use of this worksheet.

F252-056-000 worksheet/cervical & cervico-dorsal 5-05

Guidelines For Cervical and Cervico-Dorsal Impairment (Category Rating System)

Use of these guidelines is NOT required. You are encouraged to use them as you deem appropriate. These tools are NOT hard and fast rules. They are intended to offer guidance. As always, sound medical judgment should be used in application of these materials. If you prefer to refer directly to the WACs, see page V 8.

This two-page guideline attempts to give better definition and clarity to terms used in the Category Rating System, such as "mild but significant," "moderate," and "marked." As such, the "Doctor's Worksheet" and this guideline are companion documents, to be used together to avoid problems that might be encountered in the WAC.

These guidelines should not be construed as rigid rules, but rather basic guidelines intended to offer general guidance to clinicians in the use and interpretation of the Washington State Category System as it relates to cervical and cervico-dorsal impairment.

In all sections of these guidelines, examiners should only consider findings which are consistent with the clinical picture.

1) Atrophy

For the arm or forearm, a difference in circumference of:

- 1-1.9 cm. = mild
- 2-2.9 cm = moderate
- 3+ cm = marked.

Atrophy should not be considered in the rating if it can be explained by non-spine-related problems (for example, wrist fracture) or contralateral hypertrophy, as might occur with a dominant limb or greatly increased use of a limb.

2) EMG Abnormalities

EMG abnormalities are considered significant if unequivocal electrodiagnostic evidence exists of acute nerve root compromise, such as multiple positive sharp waves or fibrillation potentials; or H-wave absence or delay greater than 3 mm/sec; or chronic changes such as polyphasic waves in peripheral muscles.

3) Muscle Weakness

- Mild = 4/5 (Complete motion against gravity and less than full resistance);
- Moderate = 3/5 (Barely complete motion against gravity);
- Marked = 2/5 - 0/5 (Complete motion with gravity eliminated, to no evidence of contractility)

4) Reflex Loss

In general, only asymmetric reflex losses should be considered significant for the purposes of impairment rating.

5) X-ray or Imaging Findings

The categorization given below is NOT intended to be a comprehensive list of findings which may be described as mild, moderate or marked. *Also, be sure to only include findings which are consistent with the clinical picture.*

Mild	Moderate	Marked
Any of the following without hypermobility or radiculopathy: • spondylolysis • spondylolisthesis • vertebral body fracture with less than 25% compression of one vertebral body • post-surgical state	• hypermobility or translation >3.5 mm at a single level • vertebral body fracture with 25-50% compression of one vertebral body	• hypermobility or translation > 3.5 mm at multiple levels • vertebral body fracture with > 50% compression of one vertebral body
Other findings: * Disc bulge or degenerative changes in the absence of concurrent clinical presentation should be considered insignificant. * Disc narrowing, spurring, and arthrosis are part of the aging process and **may** be considered insignificant, depending on the circumstances of the individual patient. However, principles pertaining to preexisting conditions must be considered. For example, an industrial injury can "light up" degenerative changes in a 55-year-old worker which may result in the payment of an award for impairment. See "Preexisting Conditions and Segregation" on Pages V 4-6		

6) Miscellaneous Findings

The chart below is NOT intended to be a comprehensive list of findings which may be considered for the purposes of impairment ratings. *Also, be sure to only include findings which are consistent with the clinical picture.*

These should <u>not</u> be considered in an impairment rating:	These <u>may</u> be considered in an impairment rating:
• Pain scales (for example, the Oswestry pain scale)	• Dermatomal sensory loss • Muscle guarding • Asymmetric loss of active range-of-motion • Foraminal compression test, i.e., upper extremity symptoms in a radicular pattern (Spurling's maneuver)

Case Examples of Cervical Back Impairment

As you rate the examples of cervical impairment below, consider how the objective findings fit into Columns A-C of the "Doctor's Worksheet" (see previous section). Column A=nerve root involvement; Column B=neck rigidity substantiated by imaging; Column C=range-of-motion, spasm, and other findings. Averages should be rounded to the nearest whole number (1.1=1, 1.5=2, etc.).

Also, keep in mind that there is no single "correct" rating for these 7 case examples. See page V 15 for further discussion of this point.

Use of these case examples for guidance is NOT required. You are encouraged to use them as you deem appropriate. These tools are NOT hard and fast rules. They are intended to offer guidance. As always, sound medical judgment should be used in application of these materials. If you prefer to refer directly to the WACs, see Page V 8.

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1. A 45-year-old insurance salesman has a 6 month history of neck pain, bilateral arm pain, and numbness of the thumb and index finger on the right. There is no weakness of specific muscle groups. Reflexes are 1+ and symmetrical in the upper extremities. The foramina compression test is positive for neck pain, but there is no radicular pain on either side. Cervical range of motion was 30 degrees on right rotation (80 degrees on the left), and 10 degrees on right lateral flexion (30 degrees on the left). There was decreased sensation to pinprick in the C6 dermatome. Moderate palpable and visible cervical spasms were observed. Cervical spine films revealed a loss of cervical lordosis but disc heights were normal and there was no significant spurring or osteophyte formation.

OBJECTIVE FINDINGS TO SUPPORT RATING:

COLUMN:	A +	B +	C	=	TOTAL	AVERAGE (Total/3 rounded to the nearest whole number)
	2 +	2 +	3	=	7	CATEGORY 2

2. A 35-year-old man has neck pain radiating into the upper thoracic area bilaterally. He has give-way weakness in the upper extremities and all major muscle groups tested. There is no muscle atrophy and his EMG within the past four months was negative. Reflexes were 2+ and symmetrical in the upper extremities. Foramina compression testing was positive for neck pain, but no radicular pain. There was no significant muscle spasm and neck range of motion was essentially within normal limits. The cervical spine films were normal, with no loss of cervical lordosis.

OBJECTIVE FINDINGS TO SUPPORT RATING:

COLUMN:	A +	B +	C	=	TOTAL	AVERAGE (Total/3 rounded to the nearest whole number)
	+	+	+	=		CATEGORY

3. A 55-year-old woman has chronic neck pain with radiation to the right arm associated with weakness (3/5) of her biceps and deltoid on the right. She has a 2.2 cm muscle atrophy in the right upper arm and a decreased right biceps reflex. The foramina compression test was positive on the right with radicular pain. Active neck extension and flexion were markedly restricted. Moderate palpable and visible cervical spasm were observed. Cervical spine films revealed a 50% loss of disc height at C4-C5 and C5-C6 with hypermobility of 3.5 mm at C4-C5 on flexion and extension. She has had no cervical surgery. Her EMG several months previously had revealed evidence of a chronic, right-sided C-5 radiculopathy.

OBJECTIVE FINDINGS TO SUPPORT RATING:

COLUMN:	A +	B +	C	=	TOTAL	AVERAGE (Total/3 rounded to the nearest whole number)
	+	+	+	=		CATEGORY

4. A 28-year-old logger fell from a 15-foot height and developed bilateral arm weakness and numbness. He underwent emergency myelogram which revealed the presence of a very large central herniated disc at C4-5 pressing on the spinal cord and producing bilateral foramina stenosis. He underwent emergency surgery, but continued to have residual bilateral arm pain and loss of the biceps reflex on the left. He had residual weakness of the biceps on the left as well (3/5) with a 2.0 cm reduction in the left upper arm compared to the right. Active neck extension and flexion were moderately restricted. Moderate palpable and visible cervical spasm were observed.

OBJECTIVE FINDINGS TO SUPPORT RATING:

COLUMN:	A +	B +	C	=	TOTAL	AVERAGE (Total/3 rounded to the nearest whole number)
	+	+	+	=		CATEGORY

5. A 35-year-old man had undergone two cervical anterior interbody fusions, initially at C6-C7 and then later at C5-C6. He suffered from chronic neck pain and headaches. On examination he had 3 cm of atrophy of the right upper arm and a diminished triceps reflex on the right. He had sensory loss in the right middle finger. His bowel and bladder functions were intact. Foramina compression test was positive on the right for neck pain with radiation to the right arm. Triceps strength was 2/5 on the right. Active neck extension and flexion were moderately restricted. No spasm was observed.

OBJECTIVE FINDINGS TO SUPPORT RATING:

COLUMN:	A +	B +	C	=	TOTAL	AVERAGE (Total/3 rounded to the nearest whole number)
	+	+	+	=		CATEGORY

6. A 45-year-old landscaper has a past history of multiple previous injuries resulting in a previous cervical-dorsal rating of Category II. He experienced a new injury in January of 1995 and at the time of the IME, treatment had plateaued. His subjective complaints consisted of ongoing neck and right arm pain and he was requesting vocational assistance. On exam the foramina compression test was positive on the right for radicular pain. His right biceps reflex was diminished compared to the left. There was no muscle atrophy or weakness. Hypesthesia was present in the C6 distribution. Active neck flexion was limited to 30 degrees. Mild to moderate palpable and visible cervical spasm were observed. X-rays demonstrated a 25% loss of disc height at C5-C6 with some mild anterior spurring at multiple levels in the cervical spine.

OBJECTIVE FINDINGS TO SUPPORT RATING:

COLUMN:	A +	B +	C	=	TOTAL	AVERAGE (Total/3 rounded to the nearest whole number)
	+	+	+	=		CATEGORY

7. A 51-year-old shuttle driver injured his neck when rear-ended at the airport. He reported left hand tingling, numbness and weakness. Exam revealed cervical rigidity and spasm and left C5 sensory/motor changes. MRI revealed disc protrusion at C4-5 with left C5 nerve root impingement. Treatment was discectomy/fusion at C4-5 followed by extensive physical therapy for 6 months. Exam revealed cervical range of motion slightly limited, no spasm and normal neurological exam. EMG revealed a persistent C5 radiculopathy.

OBJECTIVE FINDINGS TO SUPPORT RATING:

COLUMN:	A +	B +	C	=	TOTAL	AVERAGE (Total/3 rounded to the nearest whole number)
	+	+	+	=		CATEGORY

Suggested Ratings for Seven Case Examples of Cervical Impairment from Previous Section

There is no single "correct" rating for any of these 7 case examples (Pages V 13-15). This is partly because there are bound to be reasonable differences in how clinicians interpret the facts presented in these vignettes. In real-life cases, sound medical judgment will play an important role, and you might elicit additional information that would lead to a different rating. Doctors should understand that there is considerable flexibility in the Category Rating System. It is not necessary to be unduly rigid in interpreting the regulations or the guidelines presented in this Handbook.

That said, here are reasonable ratings for these vignettes. The numbers in parentheses refer to the numbers which would be circled in Columns A-C, in that order, of the "Doctor's Worksheet" (see previous section). Column A=nerve root involvement; Column B=neck rigidity substantiated by imaging; Column C=range-of-motion, spasm, and other findings. The numbers are added and averaged as on the worksheet, rounding to the nearest whole number (1.3=1, 1.6=2, etc.).

CASE # 1: Category 2 (2+2+3 = 7; 7 ÷ 3 = 2.3, rounds to Category 2)

CASE # 2: Category 1 (1+1+1 = 3; 3 ÷ 3 = 1 , Category 1)

CASE # 3: Category 4 (5+4+3 = 12; 12 ÷ 3 = 4, Category 4)
Or Category 4 (5+4+4 = 13 13 ÷ 3 = 4.3, rounds to Category 4)

CASE # 4: Category 4 (5+3+3 = 11; 11 ÷ 3 = 3.6, rounds to Category 4)

CASE # 5: Category 5 (5+4+3 = 12; 12 ÷ 3 = 4 , Category 4)

CASE # 6: Category 2 (2+3+2 = 7; 7 ÷ 3 = 2.3, rounds to Category 2)
Or Category 2 (2+3+3 = 8; 8 ÷ 3 = 2.6, rounds to Category 3)

CASE # 7: Category 2 (2+3+1 = 6; 6 ÷ 3 = 2 , Category 2)
Or Category 2 (2+3+2 = 7; 7 ÷ 3 = 2.3, rounds to Category 2)

B. Dorsal Spine

General Principles

Several general principles should be followed when rating dorsal impairment. These include the following:

- **Dorsal/cervical and dorsal/lumbar combinations**: For patients who have spinal pathology that involves the dorsal and lumbar regions (for example, involvement of T11-L2; or to give a second example, T5-T6 and L4-L5), impairment must be rated using ONLY the dorsolumbar and lumbosacral categories described in WAC 296-20-280 (NOT the categories for the dorsal spine). The same principle applies to pathology involving the cervical and dorsal regions.
- **Bladder and/or bowel sphincter impairments**: Objectively demonstrated bladder and/or bowel sphincter impairments must be evaluated separately, using the Washington State Category Rating System. See "Digestive Tract" and "Urologic" sections.

Rules (WAC 296-20-250)

1. Rules for evaluation of permanent dorsal area impairments are as follows:
   a. Muscle spasm or involuntary guarding, bony or fibrous fusion, any arthritic condition, internal fixation devices or other physical finding shall be considered, in selection of the appropriate category, only insofar as productive of dorsal area impairment.
   b. Gradations of clinical findings of dorsal impairments in terms of "mild", "moderate" or "marked" shall be based on objective medical tests.
   c. Categories 2 and 3 include the presence of complaints of whatever degree.
   d. Bladder and/or bowel sphincter impairments deriving from impairments of the dorsal area shall be evaluated separately.
   e. Impairments which also involve the cervical or lumbar areas shall be evaluated only under the cervical and cervico-dorsal or dorsolumbar and lumbosacral categories.

Categories (WAC 296-20-260)

Choose the category below which best describes the patient's impairment:

Category 1. No objective clinical findings are present. Subjective complaints may be present or absent.

Category 2. Mild or moderate dorsal impairment, with objective clinical findings of such impairment, without significant objective neurological findings, with or without x-ray changes of narrowed intervertebral disc spaces and/or osteoarthritic lipping of intervertebral margins. Includes the presence or absence of reflex and/or sensory losses.

- This and the subsequent category include the presence or absence of pain, locally or radiating from the dorsal area.

Category 3. Marked dorsal impairment, with marked objective clinical findings, with marked x-ray findings of narrowed intervertebral disc spaces and/or osteoarthritic lipping of vertebral margins, with significant objective neurological deficits, complaints and/or findings, deriving from dorsal impairment.

C. Dorso-Lumbar and Lumbo-Sacral Spine

General Principles for Low Back Impairment

Several general principles should be followed when rating low back impairment. These include the following:

- **Bladder and/or bowel sphincter impairments:** Objectively demonstrated bladder and/or bowel sphincter impairments must be evaluated separately, using the Washington State Category Rating System. See "Digestive Tract" and "Urologic" sections.
- **Laminectomy, discectomy, and fusion:** Laminectomy, discectomy and fusion should only be considered in rating impairment to the extent that they produce dorso-lumbar or lumbo-sacral impairment.
- **Worksheet:** Examiners may find it helpful to refer to the worksheet, guidelines and case examples on Pages V 19-21.

Rules (WAC 296-20-270)

1. Rules for evaluation of permanent dorso-lumbar and lumbo-sacral impairments are as follows:
   a. Muscle spasm or involuntary guarding, bony or fibrous fusion, any arthritic condition, internal fixation devices or other physical finding shall be considered, in selecting the appropriate category, only insofar as productive of low back impairment.
   b. Gradations of clinical findings of low back impairments in terms of "mild", "moderate" or "marked" shall be based on objective medical tests.
   c. All of the low back categories include the presence of complaints of whatever degree.
   d. Any and all neurological deficits, complaints, and/or findings in other bodily areas or systems which are the result of dorso-lumbar and lumbo-sacral impairments, except for objectively demonstrated bladder and/or bowel sphincter impairments, shall be evaluated by the descriptions contained in the categories of dorso-lumbar and lumbo-sacral impairments.
   e. Bladder and/or bowel sphincter impairments deriving from dorso-lumbar and lumbo-sacral impairments shall be evaluated separately.
   f. Low back as used in these rules and categories includes the lumbar and adjacent areas.

Categories (WAC 296-20-280)

Choose the category below which best describes the patient's impairment:

Category 1. No objective clinical findings. Subjective complaints and/or sensory losses may be present or absent.

Category 2. Mild low back impairment, with mild intermittent objective clinical findings of such impairment but no significant x-ray findings and no significant objective motor loss. Subjective complaints and/or sensory losses may be present.

Category 3. Mild low back impairment, with mild continuous or moderate intermittent objective clinical findings of such impairment but without significant x-ray findings or significant objective motor loss. This and subsequent categories include:

- the presence or absence of reflex and/or sensory losses;
- the presence or absence of pain locally and/or radiating into an extremity or extremities;
- the presence or absence of a laminectomy or discectomy with normally expected residuals.

Category 4. Mild low back impairment, with mild continuous or moderate intermittent objective clinical findings of such impairment, with mild but significant

x-ray findings and with mild but significant motor loss objectively demonstrated by atrophy and weakness of a specific muscle or muscle group. This and subsequent categories include the presence or absence of a surgical fusion with normally expected residuals.

Category 5. Moderate low back impairment, with moderate continuous or marked intermittent objective clinical findings of such impairment, with moderate x-ray findings and with mild but significant motor loss objectively demonstrated by atrophy and weakness of a specific muscle or muscle group.

Category 6. Marked low back impairment, with marked intermittent objective clinical findings of such impairment, with moderate or marked x-ray findings and with moderate motor loss objectively demonstrated by atrophy and weakness of a specific muscle or muscle group.

Category 7. Marked low back impairment, with marked continuous objective clinical findings of such impairment, with marked x-ray findings and with marked motor loss objectively demonstrated by marked atrophy and weakness of a specific muscle or muscle group.

Category 8. Essentially total loss of low back functions, with marked x-ray findings and with marked motor loss objectively demonstrated by marked atrophy and weakness of a muscle group or groups.

Guidelines For Dorso-Lumbar and Lumbo-Sacral Impairment (Category Rating System)

Use of these guidelines is NOT required. You are encouraged to use them as you deem appropriate. These tools are NOT hard and fast rules. They are intended to offer guidance. As always, sound medical judgment should be used in application of these materials. If you prefer to refer directly to the WACs, see Pages V 16-17.

This two-page guideline attempts to give better definition and clarity to terms used in the Category Rating System, such as "mild but significant," "moderate," and "marked." As such, the "Doctor's Worksheet" and this guideline are companion documents, to be used together to avoid problems that might be encountered in the WAC.

These guidelines should not be construed as rigid rules, but rather basic guidelines intended to offer general guidance to clinicians in the use and interpretation of the Washington State Category System as it relates to dorso-lumbar and lumbo-sacral impairment.

In all sections of these guidelines, examiners should only consider findings which are consistent with the clinical picture.

---

1) Atrophy

For the calf or thigh, a difference in circumference of:

- 1-1.9 cm. = mild
- 2-2.9 cm = moderate
- 3+ cm = marked.

Atrophy should not be considered in the rating if it can be explained by non-spine-related problems (for example, ankle fracture) or contralateral hypertrophy, as might occur with a dominant limb or greatly increased use of a limb.

2) EMG Abnormalities

EMG abnormalities are considered significant if unequivocal electrodiagnostic evidence exists of acute nerve root compromise, such as multiple positive sharp waves or fibrillation potentials; or H-wave absence or delay greater than 3 mm/sec; or chronic changes such as polyphasic waves in peripheral muscles.

3) Muscle Weakness

- Mild = 4/5 (Complete motion against gravity and less than full resistance);
- Moderate = 3/5 (Barely complete motion against gravity);
- Marked = 2/5 - 0/5 (Complete motion with gravity eliminated, to no evidence of contractility)

4) Reflex Loss

In general, only asymmetric reflex losses should be considered significant for the purposes of impairment rating.

5) X-ray or Imaging Findings

The categorization given below is NOT intended to be a comprehensive list of findings which may be described as mild, moderate or marked. **Also, be sure to only include findings which are consistent with the clinical picture.**

MILD	MODERATE	MARKED
Any of the following without hypermobility or radiculopathy: • spondylolysis • spondylolisthesis • vertebral body fracture with < 25% compression of one vertebral body • post-surgical state	• hypermobility or translation > 4.5 mm at a single level • vertebral body fracture with 25-50% compression of one vertebral body	• hypermobility or translation >4.5 mm at multiple levels • vertebral body fracture with > 50% compression of one vertebral body
Other findings: * Disc bulge or degenerative changes in the absence of concurrent clinical presentation should be considered insignificant. * Disc narrowing, spurring, and arthrosis are part of the aging process and may be considered insignificant, depending on the circumstances of the individual patient. However, principles pertaining to preexisting conditions must be considered. For example, an industrial injury can "light up" degenerative changes in a 55-year-old worker which may result in the payment of an award for impairment. See "Preexisting Conditions and Segregation" on Pages V 4-5.		

6) Miscellaneous Findings

The listing given below is NOT intended to be a comprehensive list of findings which may be considered for the purposes of impairment ratings. **Also, be sure to only include findings which are consistent with the clinical picture.**

THESE SHOULD NOT BE CONSIDERED IN AN IMPAIRMENT RATING:	THESE MAY BE CONSIDERED IN AN IMPAIRMENT RATING:
• Pain scales (for example, the Oswestry pain scale)	• Dermatomal sensory loss • Positive straight-leg-raising with a radicular pattern • Muscle guarding • Asymmetric loss of active range-of-motion • Femoral nerve stretch • Foraminal compression test, i.e., lower extremity symptoms in a radicular pattern (Kemps sign) • Waddell's signs*
* Waddell's signs are non-organic physical signs in low back pain (such as axial loading and cogwheel "give-way" weakness). They are distinguishable from the standard clinical signs of physical pathology and correlate with other psychological data. For more information, see Waddell, G., et al.: Non-organic physical signs in low back pain, *Spine* 5:117, 1980.	

Doctor's Worksheet for Rating Dorso-Lumbar & Lumbo-Sacral Impairment

Instructions:

To improve consistency, fairness and "user friendliness," a worksheet has been developed through a cooperative effort with representatives of the medical, osteopathic, and chiropractic communities, along with input from representatives of business, labor, and the legal community.

- The worksheet is only one page. The worksheet, itself, serves as the rating report (when it is filled out completely, signed and dated by the doctor).

Attending Doctors: This worksheet is all you need to send to the claim manager if you are the attending doctor (assuming that you have provided all the required documentation - chart notes, history and physical, etc.). Please attach a separate note to provide additional detail when appropriate. For example, it can be important to the claimant if there is a worsening of the condition and a re-opening application is filed. In such cases, details about the findings at the time of the impairment rating will generally be needed to compare with the findings at the time of application to reopen the claim.

IME examiners and consultants: You should attach the worksheet to the full IME report as described on pages III 1-2. Please include additional detail in your full IME report if more space is required.

- Caution **regarding SEVERE impairment:** This worksheet is NOT designed for the rare patient with "essentially total loss of low back functions" or with "marked" atrophy and muscle weakness. For a patient such as this, you should refer to the WACs on Pages V 16-17.
- Caution **regarding PREEXISTING conditions:** As with any impairment rating, examiners should be familiar with procedures when a claimant has preexisting conditions. Please refer to Pages V 4-5 of this handbook for details.
- Bladder and/or bowel sphincter impairment: Objectively demonstrated bladder and/or bowel sphincter impairments must be evaluated separately. See "Digestive Tract" and "Urologic" sections. This impairment should be reported by attaching a separate page to the worksheet. (Be sure to put the patient's name and claim number on every page of all attachments in case they become separated from the worksheet.)
- The worksheet should be used in conjunction with the WACs. You should read and be familiar with the WACs on Pages V 16-17. You may also find it helpful to use the guidelines on Page V-18 and the case examples on Pages V 22-24.

Why was the worksheet designed this way?: You may wonder why the Worksheet and Guidelines were designed the way they were. Part of the explanation is that both tools must, of necessity, be consistent with the Category Rating System. They do not, and cannot, replace the Category Rating System. The Category Rating System is established in the Washington Administrative Code (WAC). As such, it can only be changed through a formal process involving public hearings and broad stakeholdering, including stakeholdering with the Business and Labor communities.

The worksheet, along with a SAMPLE worksheet filled out for a case example, are included on the following pages. Please feel free to photocopy the worksheet.

Use of the worksheet is NOT required. You are encouraged to use it as you deem appropriate. These tools are NOT hard and fast rules. They are intended to offer guidance. As always, sound medical judgment should be used in application of these materials. If you prefer to refer directly to the WACs, see Pages V 16-17.

Doctor's Worksheet for Rating Dorso-Lumbar & Lumbo-Sacral Impairment

Example

Mr. X, a 28 year old male, was injured when lifting a 50 pound container out of a van. He developed sharp back pain, radiating down the left leg into the left foot. The patient received non-operative treatment, including physical therapy and non-steroidal medications. At the time of the impairment rating examination Mr. X reported moderate intermittent pain. Physical examination was unremarkable except for diminished ankle jerk on the left and tenderness at L4-L5 and L5-S1 with deep pressure. MRI showed central disc herniation at L5-S1 slightly eccentric to the left not impinging on a nerve root. The worksheet for Mr. X would look like the Sample Worksheet below.

A	B	C		D	
Muscle Weakness ***AND:*** **EITHER Atrophy or EMG abnormalities** (See "notes" below.)	**Reflex loss** *(In general only Asymmetric losses are significant.)*	**Imaging and X-ray findings** **EXAMPLES:** Degenerative disk disease, fracture disrupting the spinal canal, bulging disc ***(Only include findings which are consistent with clinical picture.)***		**Other Findings** **EXAMPLES:** Dermatomal sensory loss, decreased range-of-motion, muscle guarding, +SLR ***(Only include findings which are consistent with the clinical picture.)*** NOT TO BE CONSIDERED: OSWESTRY OR OTHER PAIN SCALES	
Circle one	**Circle one**	**Circle one**	**Explain:**	**Circle one**	**Explain:**
none **(1)**	none **(1)**	none **(1)**	**MRI shows central disc herniation at L5-S1 not impinging on nerve root.**	none **(1)**	
				mild intermittent **(2)**	
	knee ☐ yes ankle ☐ yes **(3)**			mild continuous or moderate intermittent **(3)**	
mild but significant **(4)**		mild but significant **(4)**			
		moderate **(5)**		moderate continuous or marked intermittent **(5)**	
moderate **(6)**		marked **(6)**			
marked **(7)**				marked continuous **(7)**	
Give muscle group and specific abnormalities:				essentially total loss of low back functions **(8)**	

Step 4: Calculate Rating *(If you want L&I to do the calculation, copy the numbers into the 1st 4 boxes and go to Step 5.)*

Box number circled in Column A:	**1**
Box number circled in Column B:	**3**
Box number circled in Column C:	**4**
Box number circled in Column D:	**1**
Total	**9**
Average (total divided by 4)	**2.25**
Enter the average rounded to nearest whole number (1.1=1, 1.5=2, etc.) This is the rating:	**2**

Section **V**

Notes: • Column A: **Mild Weakness** = 4/5 (Complete motion against gravity and less than full resistance);
Moderate = 3/5 (Barely complete motion against gravity);
Marked = 2/5 - 0/5 (Complete motion with gravity eliminated to no evidence of contractility).

• Pain is considered in the rating, but must be reflected in findings described on this worksheet (for example, decreased range-of-motion).

Step 5: Certification

I certify that I have examined the patient within the last 8 weeks and that the above report truly and correctly sets forth my findings and opinion.

Doctor's address: **123 Maple Dr. Seattle, WA 98xxx-xxxx** ZIP+4 | Provider No.: **12345**

Print Dr's name: **John Smith M.D.** | Today's date: **1/1/05** | Doctor's signature: *John Smith M.D.*

Developed jointly by representatives of the medical, osteopathic and chiropractic communities with input from Labor and Business; based on WAC 296-20-280

F252-006-000 worksheet/dorso-lumbar & lumbo sacral 9-00

Department of Labor & Industries

Doctor's Worksheet for Rating Dorso-Lumbar & Lumbo-Sacral Impairment

Claimant's name

Claim #

Step 1. (a) Has the worker's condition reached maximum medical improvement? ☐ Yes ☐ No If "No," do not rate. Please provide treatment recommendations.
(b) If there is a pre-existing condition, was it permanently aggravated by the industrial injury? ☐ Yes ☐ No ☐ N/A If "Yes," attach explanation.
Step 2. Is there any permanent impairment? ☐ Yes ☐ No
Step 3. Circle one box in each column A through D below. Give brief explanation below (REQUIRED). *Your entries should reflect the patient's current*

A	B	C		D	
Muscle Weakness *AND:* EITHER Atrophy or EMG abnormalities (See "notes" below.)	**Reflex loss** *(In general only Asymmetric losses are significant.)*	**Imaging and X-ray findings** **EXAMPLES:** Degenerative disk disease, fracture disrupting the spinal canal, bulging disc ***(Only include findings which are consistent with clinical picture.)***		**Other Findings** **EXAMPLES:** Dermatomal sensory loss, decreased range-of-motion, muscle guarding, +SLR ***(Only include findings which are consistent with the clinical picture.)*** NOT TO BE CONSIDERED: OSWESTRY OR OTHER PAIN SCALES	
Circle one	**Circle one**	**Circle one**	**Explain:**	**Circle one**	**Explain:**
none **(1)**	none **(1)**	none **(1)**		none **(1)**	
				mild intermittent **(2)**	
	knee ☐ yes ankle ☐ yes **(3)**			mild continuous or moderate intermittent **(3)**	
mild but significant **(4)**		mild but significant **(4)**			
		moderate **(5)**		moderate continuous or marked intermittent **(5)**	
moderate **(6)**		marked **(6)**			
marked **(7)**				marked continuous **(7)**	
Give muscle group and specific abnormalities:				essentially total loss of low back functions **(8)**	

Tear on perforated line

Step 4: Calculate Rating *(If you want L&I to do the calculation, copy the numbers into the 1st 4 boxes and go to Step 5.)*

Box number circled in Column A:	
Box number circled in Column B:	
Box number circled in Column C:	
Box number circled in Column D:	
Total	
Average (total divided by 4)	
Enter the average rounded to nearest whole number (1.1=1, 1.5=2, etc.) This is the rating:	

Section V

Notes:
- Column A: **Mild Weakness** = 4/5 (Complete motion against gravity and less than full resistance); **Moderate** = 3/5 (Barely complete motion against gravity); **Marked** = 2/5 - 0/5 (Complete motion with gravity eliminated to no evidence of contractility).
- Pain is considered in the rating, but must be reflected in findings described on this worksheet (for example, decreased range-of-motion).

Step 5: Certification

I certify that I have examined the patient within the last 8 weeks and that the above report truly and correctly sets forth my findings and opinion.

Doctor's address | ZIP+4 | Provider No.

Print Dr's name | Today's date | Doctor's signature

The Physician should photocopy this worksheet for their medical records. Doctors should refer to the Medical Examiner's Handbook *for instructions on the use of this worksheet.*

Developed jointly by representatives of the medical, osteopathic and chiropractic communities with input from Labor and Business; based on WAC 296-20-280

F252-006-000 worksheet/dorso-lumbar & lumbo sacral 9-00

Case Examples of Low Back Impairment

As you rate the examples of low back impairment below, consider how the objective findings fit into Columns A-D of the "Doctor's Worksheet" (see previous section). Column A=muscle weakness, atrophy, EMG; Column B=reflex loss; Column C=imaging and x-ray findings; Column D=other findings. Averages should be rounded to the nearest whole number (1.1=1, 1.5=2, etc.).

Also, keep in mind that there is no single "correct" rating for these 11 case examples. See page V 24 for further discussion of this point.

Use of these case examples is NOT required. You are encouraged to use them as you deem appropriate. These tools are NOT hard and fast rules. They are intended to offer guidance. As always, sound medical judgment should be used in application of these materials. If you prefer to refer directly to the WACs, see pages V 16-17.

1. A 45-year-old man has a six month history of mild low back pain, bilateral sciatica, and subjective numbness of the right fifth toe. There is no weakness of specific muscle groups. Reflexes are 1+ and symmetrical at the knee and ankle. Straight leg produces low back pain at 80 degrees of hip flexion bilaterally. Sensory exam is within normal limits. Lumbar spine films show mild spurring at L4-5. MRI reveals loss of disc height and desiccation at L4-5 and L5-S1. There is a moderate sized central lumbar disc protrusion at L1-2 without impingement on the thecal sac.

OBJECTIVE FINDINGS TO SUPPORT RATING:

COLUMN: A +	B +	C +	D =	TOTAL	AVERAGE (Total/4 rounded to the nearest whole number)
1 +	1 +	4 +	1 =	7	CATEGORY 2

2. A 22-year-old grocery clerk has low back pain, radiating to the buttocks bilaterally, no neurological deficit. Give-way weakness in the lower extremities and all major muscle groups tested. No muscle atrophy. Reflexes two plus and symmetrical at patellar and Achilles tendons. Supine SLR negative (producing only low back pain at 30 degrees bilaterally). Sitting SLR negative to 90 degrees. Axial loading and en bloc rotation of the torso produce low back pain. Lumbar spine films normal. CT scan reveals loss of disc height at L5-S1 but is otherwise within normal limits.

OBJECTIVE FINDINGS TO SUPPORT RATING:

COLUMN: A +	B +	C +	D =	TOTAL	AVERAGE (Total/4 rounded to the nearest whole number)
+	+	+	=		CATEGORY

3. A 36-year-old meat wrapper had low back pain and left lower extremity (thigh and leg) pain with weakness of hamstrings and EHL on the left. MRI revealed a herniated disc at L4-5 on the left. Laminotomy and discectomy were performed at L4-5 on the left, with relief of lower limb (but not back) pain. On examination, he has residual sensory radiculopathy in the left L5 distribution. There is no weakness in specific muscle groups. Patellar and Achilles tendon reflexes were symmetrical. SLR was positive on the left for radicular pain. No follow-up diagnostic studies had been obtained.

OBJECTIVE FINDINGS TO SUPPORT RATING:

COLUMN: A +	B +	C +	D =	TOTAL	AVERAGE (Total/4 rounded to the nearest whole number)
+	+	+	=		CATEGORY

4. A 28-year-old logger fell from a 15 foot height and developed bilateral lower extremity weakness and numbness plus loss of bowel and bladder control. Emergency myelogram revealed a large central herniated disc at L1-2 pressing on the conus medullaris and a left posterolateral disc herniation at L5-S1. Following emergency discectomy, he regained bowel and bladder control but has residual bilateral sciatica, loss of Achilles tendon reflex on the left, and residual 2/5 weakness on ankle plantar flexion. Left leg circumference was 3.0 cm smaller due to calf muscle atrophy. There was loss of sensation in the S1 nerve root distribution; guarding at the L5-S1 level; SLR positive for radicular pain. Repeated office visits have revealed a consistent pattern of asymmetric range-of-motion limitation, including decreased extension and left lateral flexion.

OBJECTIVE FINDINGS TO SUPPORT RATING:

COLUMN: A +	B +	C +	D =	TOTAL	AVERAGE (Total/4 rounded to the nearest whole number)
+	+	+	=		CATEGORY

5. A 35-year-old male had chronic low back pain. X-ray revealed grade two spondylolisthesis. At nine months of low back pain, he underwent lumbar fusion. Currently, x-rays reveal the presence of one-level lumbar fusion at L5-S1. Examination is entirely within normal limits. There are no neurological symptoms or signs.

OBJECTIVE FINDINGS TO SUPPORT RATING:

COLUMN: A +	B +	C +	D =	TOTAL	AVERAGE (Total/4 rounded to the nearest whole number)
+	+	+	=		CATEGORY

6. A 54-year-old woman has chronic low back pain and lateral right thigh pain, numbness of the right anterolateral leg, and grade 3/5 weakness of the EHL and hamstrings on the right. Right leg circumference is 2.5 cm smaller due to muscle atrophy. Reflexes are intact. Positive SLR on right at 45 degrees with radicular pain and increased pain on dorsiflexion of the right ankle. Lumbar spine films reveal 50% loss of disc height at L4-5 and L5-S1 and hypermobility of 6mm at L4-L5 and at L5-S1 on flexion and extension. EMG reveals evidence of chronic right L5 radiculopathy.

OBJECTIVE FINDINGS TO SUPPORT RATING:

COLUMN: A +	B +	C +	D =	TOTAL	AVERAGE (Total/4 rounded to the nearest whole number)
+	+	+	=		CATEGORY

7. A 35-year-old chronic pain patient has undergone five lumbar surgeries, including laminotomy and discectomy at L4-5 and L5-S1, followed by repeat laminotomy-discectomy procedures times two at L4-5, and eventually L4-S1 fusion. Diagnostic studies reveal pseudoarthrosis of the lumbar fusion with 30% loss of disc height at L4-5 and L5-S1. On examination he has 1.5 cm of leg atrophy and diminished Achilles tendon reflex on the right. There is no sensory loss. Bowel and bladder function are intact. SLR is positive at 60 degrees on the right for low back pain and sciatica. There is grade 4/5 weakness on toe walking.

OBJECTIVE FINDINGS TO SUPPORT RATING:

COLUMN: A +	B +	C +	D =	TOTAL	AVERAGE (Total/4 rounded to the nearest whole number)
+	+	+	=		CATEGORY

8. A 42-year-old mechanic has low back pain radiating to the left leg and subjective hypesthesia in the calf and lateral left foot. There is no weakness or atrophy, and knee and ankle reflexes are normal. Sensation to pinprick over the left calf and lateral left foot is diminished. SLR was positive at 60 degrees on the left with increased radicular pain on ankle dorsiflexion. Kemps signs is positive for left radicular pain. X-rays show 25% loss of disc height of L5-S1.

OBJECTIVE FINDINGS TO SUPPORT RATING:

COLUMN: A +	B +	C +	D =	TOTAL	AVERAGE (Total/4 rounded to the nearest whole number)
+	+	+	=		CATEGORY

9. A 35-year-old insurance salesman has low back pain without radiation. Spasms are present at L4-L5 and L5-S1 bilaterally. Flexion is limited at 45 degrees with spasms visualized, no reversal of lumbar lordosis, and two phase recovery. SLR is negative (no radiating pain) but produces some low back discomfort. Neither weakness nor atrophy are present. X-rays show mild degenerative joint disease of L4-5 and L5-S1 facet joints bilaterally.

OBJECTIVE FINDINGS TO SUPPORT RATING:

COLUMN: A +	B +	C +	D =	TOTAL	AVERAGE (Total/4 rounded to the nearest whole number)
+	+	+	=		CATEGORY

10. A fifty-six-year-old overweight truck driver has chronic non-radiating low back pain. He has full thoracolumbar motions in all directions with pain at end-range. Soto Hall, Nachlas, Elys, and Hibbs all cause low back pain. No spasm is present. X-rays show mild degenerative disc disease throughout the lumbar spine.

OBJECTIVE FINDINGS TO SUPPORT RATING:

COLUMN: A +	B +	C +	D =	TOTAL	AVERAGE (Total/4 rounded to the nearest whole number)
+	+	+	=		CATEGORY

11. A 45-year-old female with a history of multiple previous injuries and lumbosacral Category 2 impairment rating was doing well before an industrial injury on January 12 1995. Her condition has now plateaued. Current complaints consist of ongoing low back pain and right leg pain. SLR is positive on the right at 50 degrees with radicular pain on ankle dorsiflexion. Right Achilles reflex is diminished. No atrophy or weakness is evident, but there is hypesthesia in the S1 distribution. X-rays show 25% loss of disc height at L5-S1.

OBJECTIVE FINDINGS TO SUPPORT RATING:

COLUMN:	A +	B +	C +	D =	TOTAL	AVERAGE (Total/4 rounded to the nearest whole number)
	+	+	+	=		CATEGORY

Suggested Ratings for Eleven Case Examples of Lumbo-Sacral Impairment

There is no single "correct" rating for these 11 case examples. This is partly because there are bound to be reasonable differences in how clinicians interpret the facts presented in these vignettes. In real-life cases, sound medical judgment will play an important role, and you might elicit additional information that would lead to a different rating. Doctors should understand that there is considerable flexibility in the Category Rating System. It is not necessary to be unduly rigid in interpreting the regulations or the guidelines presented in this Supplement.

That said, here are reasonable ratings for these vignettes. The numbers in parentheses refer to the numbers which would be circled in Columns A-D, in that order, of the "Doctor's Worksheet" (see previous section). Column A=muscle weakness, atrophy, EMG; Column B=reflex loss; Column C=imaging and x-ray findings; Column D=other findings. The numbers are added and averaged as on the worksheet, rounding to the nearest whole number (1.1=1, 1.5=2, etc.).

CASE # 1: Category 1 (1+1+1+1 = 4; 4/4 = 1, Category 1)
Or Category 2 (1+1+4+1 = 7; 7/4 = 1.75, rounds to Category 2)

CASE # 2: Category 1 (1+1+1+1 = 4; 4/4 = 1, Category 1)
Note: positive Waddell's Signs

CASE # 3: Category 3 (1+1+4+5 = 11; 11/4 = 2.75, rounds to Category 3)

CASE # 4: Category 5 (7+3+5+3 = 18; 18/4 = 4.5, rounds to Category 5)
Or Category 6 (7+3+5+7 = 22; 22/4 = 5.5, rounds to Category 6)

CASE # 5: Category 2 (1+1+4+1 = 7; 7/4 = 1.75, rounds to Category 2)
Or (1+1+6+1 = 9; 9/4 = 2.25, rounds to Category 2)

CASE # 6: Category 4 (6+1+5+3 = 15; 15/4 = 3.75, rounds to Category 4)
Or Category 5 (7+1+6+5 = 19; 19/4 = 4 .75, rounds to Category 5)

CASE # 7: Category 4 (4+3+6+3 = 16; 16/4 = 4, Category 4)
Or Category 5 (4+3+6+5 = 18; 18/4 = 4.5, rounds to Category 5)

CASE # 8: Category 2 (1+1+4+3 = 9; 9/4 = 2.25, rounds to Category 2)
Or Category 3 (1+1+4+5 = 11; 11/4 = 2.75, rounds to Category 3)

CASE # 9: Category 2 (1+1+4+2 = 8; 8/4 = 2, Category 2)
Or Category 3 (1+1+4+5 = 11; 11/4 = 2.75, rounds to Category 3)

CASE #10: Category 2 (1+1+4+1 = 7; 7/4 = 1.75, rounds to Category 2)

CASE #11: Category 3 (1+3+4+3 = 11; 11/4 = 2.75, rounds to Category 3)
Or (1+3+4+5 = 13; 13/4 = 3.25, rounds to Category 3)

Use of these case examples for guidance is NOT required. You are encouraged to use them as you deem appropriate. These tools are NOT hard and fast rules. They are intended to offer guidance. As always, sound medical judgment should be used in application of these materials. If you prefer to refer directly to the WACs, see pages V 16-17.

D. Pelvis

Rules (WAC 296-20-290)

(1) Rules for impairment of the pelvis:

(a) All of these categories include the presence of complaints of whatever degree.

(b) Categories 2, 5, 6 and 7 describe separate entities and more than one may be selected when appropriate. Category 9 includes the findings described in Category 3, and Category 8 includes the findings described in Category 4.

Categories (WAC 296-20-300)

Choose the category(ies) below which describes the patient's impairment (more than one category may be chosen):

Category 1. Healed pelvic fractures without displacement, without residuals; healed fractures with displacement without residuals, of: Single ramus, bilateral rami, ilium, innominate or coccyx; or healed fracture of single rami with displacement with deformity and residuals.

Category 2. Healed fractures with displacement with deformity and residuals of ilium.

Category 3. Healed fractures of symphysis pubis, without separation with displacement without residuals.

Category 4. Healed fractures of sacrum with displacement without residuals.

Category 5. Healed fracture of bilateral rami with displacement with deformity and residuals.

Category 6. Excision or nonunion of fractures of coccyx.

Category 7. Healed fractures of innominate, displaced one inch or more, with deformity and residuals.

Category 8. Healed fractures of sacrum extending into sacroiliac joint with deformity and residuals.

Category 9. Healed fractures of symphysis, displaced or separated, with deformity and residuals.

Cardiac

Rules (WAC 296-20-350)

(1) Rule for evaluation of permanent cardiac impairments:

(a) Classification of impairment using the following categories shall be based upon a carefully obtained history, thorough physical examination and the use of appropriate laboratory aids.

Categories (WAC 296-20-360)

Choose the category below which best describes the patient's impairment:

Category 1. No objective findings are present. Subjective complaints may be present or absent.

Category 2. Objective findings of mild organic heart disease but no signs of congestive heart failure. No medically appropriate symptoms produced by prolonged exertion or intensive effort or marked emotional stress.

Category 3. Objective findings of mild organic heart disease but no signs of congestive heart failure. Medically appropriate symptoms produced by prolonged exertion or intensive effort, or marked emotional stress but not by usual daily activities.

Category 4. Objective findings of moderate organic heart disease but no signs of congestive heart failure. Medically appropriate symptoms produced by prolonged exertion or intensive effort or marked emotional stress but not by usual daily activities.

Category 5. Objective findings of marked organic heart disease with minimal signs of congestive heart failure with therapy. Medically appropriate symptoms produced by usual daily activities.

Category 6. Objective findings of marked organic heart disease with mild to moderate signs of congestive heart failure despite therapy. Medically appropriate symptoms produced by usual daily activities.

Convulsive Neurologic Disorders

Rules (WAC 296-20-310)

(1) Rules for evaluation of convulsive neurological impairments:

(a) The description of categories 2, 3 and 4 include the presence of complaints of whatever degree.

Categories (WAC 296-20-320)

Choose the category below which best describes the patient's impairment:

Category 1. No electroencephalogram findings of convulsive neurological disorder. Subjective complaints may be present or absent.

Category 2. Electroencephalogram findings of convulsive neurological disorder, but on appropriate medication there are no seizures.

Category 3. Electroencephalogram findings of convulsive neurological disorder, and on appropriate medication there are each year either one through four major seizures or one through twelve minor seizures.

Category 4. Electroencephalogram findings of convulsive neurological disorder, and on appropriate medication there are each year more than four major seizures or more than twelve minor seizures.

Digestive Tract

A. Upper Digestive Tract

Rules (WAC 296-20-490)

(1) Rule for evaluation of permanent impairments of the upper digestive tract, stomach, esophagus or pancreas.

(a) Categories 2, 3, 4 and 5 include complaints of whatever degree.

Categories (WAC 296-20-500)

Choose the category below which best describes the patient's impairment:

Category 1. No objective findings are present. Subjective complaints may be present or absent.

Category 2. There are objective findings of digestive tract impairment but no anatomic loss or alteration, continuous treatment is not required and weight can be maintained at the medically appropriate level.

Category 3. There are objective findings of digestive tract impairment, or there is anatomic loss or alteration. Dietary restrictions and drugs control symptoms, signs and/or nutritional state, and weight can be maintained at least 90 percent of medically appropriate level.

Category 4. There are objective findings of digestive tract impairment, or there is anatomic loss or alteration. Dietary restrictions and drugs do not completely control symptoms, signs and/or nutritional state. Weight can be maintained at 80-90 percent of medically appropriate level.

Category 5. There are objective findings of digestive tract impairment, or there is anatomic loss or alteration. Dietary restrictions and drugs do not control symptoms, signs and/or nutritional state. Weight cannot be maintained as high at 80 percent of medically appropriate level.

B. Lower Digestive Tract

Rules (WAC 296-20-510)

(1) Rule for evaluation of permanent lower digestive tract impairments.

(a) Categories 2, 3 and 4 include the presence of complaints of whatever degree.

Categories (WAC 296-20-520)

Choose the category below which best describes the patient's impairment:

Category 1. No objective findings of impairment of lower digestive tract. Subjective complaints may be present or absent.

Category 2. The objective findings of lower digestive tract impairment are infrequent and of brief duration, and there is limitation of activities, but special diet or medication is not required, and there are neither systemic manifestations nor impairment of nutrition.

Category 3. There are objective findings of lower digestive tract impairment or anatomic loss or alteration and mild gastrointestinal symptoms with occasional disturbance of bowel function, accompanied by moderate pain and minimal restriction of diet; mild symptomatic therapy may be necessary; no impairment of nutrition.

Category 4. There are moderate to marked intermittent bowel disturbances with continual or periodic pain; there is restriction of activities and diet during exacerbations, there are constitutional manifestations such as fever, anemia or weight loss. Includes but is not limited to any permanent ileostomy or colostomy.

C. Anal Function

Rules (WAC 296-20-530)

(1) Rule for evaluation of permanent impairment of anal function.

(a) Categories 2, 3 and 4 include the presence of complaints of whatever degree.

Categories (WAC 296-20-540)

Choose the category below which best describes the patient's impairment:

Category 1. No objective findings of impairment of anal function. Subjective complaints may be present or absent.

Category 2. There are objective findings of mild organic disease, anatomic loss or alteration with loss of anal function and mild incontinence involving gas and/or liquid stool.

Category 3. There are objective findings of moderate anal disease, anatomic loss or alteration with loss of anal function and moderate incontinence requiring continual care.

Category 4. There are objective findings of marked anal disease, anatomic loss, alteration and/or complete fecal incontinence.

D. Liver and Biliary Tract

Rules (WAC 296-20-550)

(1) Rule for evaluation of permanent liver and biliary tract impairments.

(a) Categories 2, 3, 4 and 5 include complaints of whatever degree.

Categories (WAC 296-20-560)

Choose the category below which best describes the patient's impairment:

Category 1. There are no objective findings of impairment of the liver or biliary tract. Subjective complaints may be present or absent.

Category 2. There are objective findings on biochemical studies of minimal impairment of liver function with or without symptoms, or there are occasional episodes of loss of function of the biliary tract, but nutrition and strength are good.

Category 3. There are objective findings on biochemical studies of mild impairment of liver function without symptoms, or there is recurrent biliary tract impairment, but no ascites, jaundice or bleeding esophageal varices and nutrition and strength are good.

Category 4. There are objective findings on biochemical studies of moderate impairment of the liver function with jaundice, ascites, bleeding esophageal varices or gastric and nutrition and strength may be affected; or there is irreparable obstruction of the common bile duct with recurrent cholangitis.

Category 5. There are objective findings on biochemical studies of marked impairment of liver function and nutritional state is poor; or persistent jaundice, bleeding esophageal or gastric varices.

Extremity Ratings (Upper and Lower)

A. AMA *Guides* and RCW

Except for straight amputations (for which RCW is used--see Page V 28), impairment of the upper and lower extremity is generally rated using the most current version of the American Medical Association *Guides to the Evaluation of Permanent Impairment*.

B. Rating Extremities Other Than Amputations

Extremities must be evaluated by a percentage rating system. You may use any nationally recognized rating system. Please specify in your report the rating system you are using, and be sure to use the most recently published version.

Impairment due to total joint replacement must be done using the AMA *Guides*. To order the most recent version of this book, call the AMA at 1-800-621-8335.

C. Amputations

By law, your patient's monetary award for impairment from amputations is made according to the level of the amputation. Therefore, the AMA *Guides to the Evaluation of Permanent Impairment* should NOT be used for actual amputations.

The doctor should choose the level in Table 4 on the next page (from RCW 51.32.080) which best describes the patient's amputation. Your description of the impairment should correspond to one of the descriptions listed in the law. A sample report for a simple amputation is presented on page V 28.

EXAMPLE

Amputation
Mr. F. sustained an amputation of his right dominant thumb. Attempted replantation failed, and he underwent revision of the amputation to the level of the metacarpal head.

Rating: As listed in RCW 51.32.080, this amputation corresponds most closely to "amputation of thumb at metacarpophalangeal joint."

Amputation AND Additional Loss of Function:
If a patient has BOTH amputation AND additional loss of function to an extremity, two determinations need to be made:

1. Report the actual amputation, and
2. Using guidelines for rating extremities, rate the loss of function at the highest involved joint without taking into consideration the impairment caused by the actual amputation. For example, if a worker has loss of one finger and limitation of wrist motion, you would describe the amputation of the finger and then describe the impairment at the wrist.

Table 4: AMPUTATION LEVELS ACCORDING TO RCW 51.32.080

Select the level which best describes the patient's amputation.
See Appendix C 1-3 for details.

LEG

- Of leg above the knee joint with short thigh stump (3" or less below the tuberosity of ischium)
- Of leg at or above knee joint with functional stump
- Of leg below knee joint
- Of leg at ankle (Syme)
- Of foot at mid-metatarsals
- Of great toe with resection of metatarsal bone
- Of great toe at metatarsophalangeal joint
- Of great toe at interphalangeal joint
- Of lesser toes (2nd to 5th) with resection of metatarsal bone
- Of lesser toe at metatarsophalangeal joint
- Of lesser toe at proximal interphalangeal joint
- Of lesser toe at distal interphalangeal joint

ARM

- Of arm at or above the deltoid insertion or by disarticulation at the shoulder
- Of arm at any point from below the deltoid insertion to below the elbow joint at the insertion of the biceps tendon
- Of arm at any point from below the elbow joint distal to the insertion of the biceps tendon to and including mid-metacarpal amputation of the hand with resection of carpometacarpal bone
- Of thumb at interphalangeal joint
- Of index finger at metacarpophalangeal joint
- Of all fingers except the thumb at metacarpophalangeal joints
- Of thumb at metacarpophalangeal joint or with resection of metacarpal bone
- Of index finger at proximal interphalangeal joint
- Of index finger at distal interphalangeal joint
- Of middle finger at metacarpophalangeal joint or with resection of metacarpal bone
- Of middle finger at proximal interphalangeal joint
- Of middle finger at distal interphalangeal joint
- Of ring finger at metacarpophalangeal joint or with resection of metacarpal bone
- Of ring finger at proximal interphalangeal joint
- Of ring finger at distal interphalangeal joint
- Of little finger at metacarpophalangeal joint or with resection of metacarpal bone
- Of little finger at proximal interphalangeal joint
- Of little finger at distal interphalangeal joint

Hearing Loss

A. AMA *Guides* and Worksheet

In the Washington State workers' compensation system, partial impairment of hearing is rated using the most recent edition of the American Medical Association *Guides to the Evaluation of Permanent Impairment*. To assist doctors in using the *Guides*, a one-page "Hearing Impairment Calculation Worksheet" is included on page V 30-31. Doctors are encouraged to photocopy this worksheet and include the completed worksheet with the written report. In addition to the worksheet, please provide the audiogram with your report. Also, indicate if you recommend a hearing aid or other intervention.

If hearing loss is complete, report it as: (1) Complete loss of hearing in both ears, or (2) Complete loss of hearing in one ear. See RCW 51.32.080, Permanent partial disability, miscellaneous, Appendix C 1-3.

B. Audiometric Testing

Audiometric testing should be performed at least 14 hours after the last exposure to noise. Prosthetic devices (e.g., hearing aids) must not be used during the evaluation of hearing sensitivity.

There are no laws or regulations under the industrial insurance statutes pertaining to standards for audiometric testing. However, there are several laws, regulations, and policies which may be pertinent in certain cases:

- Hearing aid establishments need to be licensed and need to employ at least one licensed fitter-dispenser at all times, and must annually submit proof that all audiometric equipment at that establishment has been properly calibrated (RCW 18.35.030). This statute is administered by the Washington State Department of Health.
- Employers must establish and maintain a mandatory audiometric testing program for all employees whose exposures equal or exceed an 8-hour time-weighted average of 85 dBA, as provided in Part K of the General Occupational Health Standards (WAC 296-62-09027). Audiometric tests must be performed by a licensed or certified audiologist, otolaryngologist, or other qualified physician, or by a technician who is certified by the Council of Accreditation in Occupational Hearing Conservation. A technician who performs audiometric tests must be responsible to an audiologist, otolaryngologist, or other qualified physician. Mandatory appendices in the standard cover the audiometric testing requirements (for example, booth requirements, audiometer calibration, etc.). This regulation (WAC 296-62-090, Part K, Hearing Conservation Standard) is administered by the Department of Labor and Industries, Section of Compliance and Consultation.
- The American Medical Association *Guides to the Evaluation of Permanent Impairment*, Fifth Edition, instructs doctors to use an audiometer that is calibrated according to American National Standards Institute (ANSI) audiometer specifications S3.6-1996 (or more recent ANSI specifications). The date of the most recent audiometer calibration should be specified in each audiometry report. Also, the same regulations that apply for mandatory audiometric testing programs apply to audiometric testing to determine impairment for hearing loss claims.

C. Presbycusis

In the Washington state workers' compensation system, partial impairment of hearing is rated using the most recent edition of the American Medical Association Guides *to the Evaluation of Permanent Impairment*. Rating of work-related hearing impairment due to noise exposure is not apportioned between age-related hearing impairment and work-related hearing impairment.

Because the effect of noise on hearing does not progress after the cessation of exposure, it is important to base impairment ratings on valid audiometric testing performed as close as possible to the last work-related exposure (whenever such tests are readily available). In some cases, a claim is filed and the sole valid audiogram was performed years after the claimant has ceased working with injurious noise.

Continues on Page V 32

Department of Labor & Industries
Office of The Medical Director
PO Box 44321
Olympia WA 98504-4321

HEARING IMPAIRMENT CALCULATION WORKSHEET

Date	Date of audiogram	Claim number
10/1/05	7/5/05	A111111
Name: Joe Worker		Hours since last exposure to noise (must be more than 14): 48

A.N.S.I. 1969

Monaural Hearing Loss Formula:

([([500 Hz + 1000 Hz + 2000 Hz + 3000 Hz] ÷ 4) - 25] x 1.5) = % of loss

LEFT EAR (X)

Hz	dB level
500	35
1000	25
2000	20
3000	35
Total	115

STOP here if total is 100 or less

Avg threshold for 4 frequencies	÷ 4 =	28.75
Less threshold fence of 25 dB	- 25 =	3.75
Multiplied by 1.5 equals the % of monaural loss	x 1.5 =	5.63
Add rating for tinnitus of 0 through 5%		2.0
Total percent monaural hearing loss		7.63

RIGHT EAR (0)

Hz	dB level
500	35
1000	25
2000	20
3000	25
	105

STOP here if total is 100 or less

Avg threshold for 4 frequencies	÷ 4 =	26.25
Less threshold fence of 25 dB	- 25 =	1.27
Multiplied by 1.5 equals the % of monaural loss	x 1.5 =	1.88
Add rating for tinnitus of 0 through 5%		2.0
Total percent monaural hearing loss		3.88

Section V

STOP HERE IF EITHER OF THE MONAURAL HEARING LOSS %'s ARE ZERO!!!

****

Combined Hearing Loss Formula:

([% better ear x 5] + [% worse ear]) ÷ 6 = % of loss

% better ear: 3.88	x 5 =	19.4
Plus % worse ear	+	7.63
	Sub-Total	27.03
Sub-Total divided by 6	÷ 6 =	4.51 % Binaural Hearing Loss

F252-007-000 hearing impairment calculation worksheet 9-00

Department of Labor & Industries
Office of The Medical Director
PO Box 44321
Olympia WA 98504-4321

HEARING IMPAIRMENT CALCULATION WORKSHEET

Date	Date of audiogram	Claim number
Name		Hours since last exposure to noise (must be more than 14)

A.N.S.I. 1969

Monaural Hearing Loss Formula:

([([500 Hz + 1000 Hz + 2000 Hz + 3000 Hz] ÷ 4) - 25] x 1.5) = % of loss

LEFT EAR (X)

Hz	dB level
500	
1000	
2000	
3000	
Total	

STOP here if total is 100 or less

Avg threshold for 4 frequencies ÷ 4 = _____

Less threshold fence of 25 dB - 25 = _____

Multiplied by 1.5 equals the % of monaural loss x 1.5 = _____

Add rating for tinnitus of 0 through 5% _____

Total percent monaural hearing loss _____

RIGHT EAR (0)

Hz	dB level
500	
1000	
2000	
3000	

STOP here if total is 100 or less

Avg threshold for 4 frequencies ÷ 4 = _____

Less threshold fence of 25 dB - 25 = _____

Multiplied by 1.5 equals the % of monaural loss x 1.5 = _____

Add rating for tinnitus of 0 through 5% _____

Total percent monaural hearing loss _____

Section V

STOP HERE IF EITHER OF THE MONAURAL HEARING LOSS %'s ARE ZERO!!!

****

Combined Hearing Loss Formula:

([% better ear x 5] + [% worse ear]) ÷ 6 = % of loss

% better ear _____ x 5 = _____

Plus % worse ear + _____

Sub-Total _____

Sub-Total divided by 6 ÷ 6 = _____ % Binaural Hearing Loss

F252-007-000 hearing impairment calculation worksheet 9-00

Regardless of when the audiogram is performed, the award will be based on the schedule of benefits in effect at the time hearing loss became manifest, which is the earlier of when hearing loss required medical treatment or became disabling. "Disabling" could be demonstrated by a valid audiogram.

By way of example: An 85-year-old files a claim in 1996 for occupational hearing loss. Although his last exposure to injurious workplace noise was in 1976, the first valid audiogram was performed in 1996. The 1996 audiogram shows 10% bilateral hearing loss. Rather than pay the award according to the 1996 schedule of benefits, the department would look to the schedule in effect no later than the date of the last exposure in 1976. The department would not use a schedule of benefits later than the last date of injurious exposure. In this example, if that 85-year-old had a valid audiogram or received hearing aids in 1971 (and a hearing loss claim had not previously been filed), the department would look to the schedule in effect in 1971, as the audiogram/hearing aid would be documentation of the manifestation of the hearing loss condition.

As always, please refer to Provider Bulletins and other department publications for the most current information on this topic.

D. Tinnitus

A physician may choose to rate (or not rate) tinnitus, according to his/her medical judgment and the specifics of each individual patient. When a physician chooses to rate tinnitus, he or she must use the most recent edition of the AMA *Guides*. The physician may add up to 5% (depending on severity). (See the "Hearing Impairment Calculation Worksheet" on page V 30-31 to understand how the amount added to each ear is translated into a binaural value.) To assess severity, the physician may wish to consider such factors as: whether the tinnitus is constant or intermittent; the perceived loudness of the tinnitus; and whether the tinnitus interferes with the patient's ability to detect noises and/or interferes with perception or comprehension of speech.

According to department policy, physicians may rate tinnitus only in the presence of an otherwise compensable unilateral OR bilateral hearing loss. If there is no otherwise compensable hearing loss, there is no award for tinnitus.

Tinnitus awards cannot exceed 5% during a worker's lifetime.

Mental Health

A. Cognitive Impairment vs. Psychiatric Impairment

If an injury or illness results in impairment which is primarily psychiatric in nature, the Category Rating System should be used (described below). If the impairment is primarily cognitive in nature or involves some other dysfunction of the central nervous system, the AMA *Guides* should be used.

If there are both significant cognitive impairment and mental health impairment, then they should be rated separately using both the Category Rating System and the AMA *Guides*.

B. Stress

Stress-related conditions are not compensable as an occupational disease under the Washington Industrial Insurance Act. See WAC 296-14-300 in Appendix C 4-5.

C. Guidelines for Psychiatric Evaluation

Examiners may find it helpful to refer to pages III 7-9 for guidelines for psychiatric IMEs.

Rules (WAC 296-20-330)

1. Rules for evaluation of permanent impairment of mental health:
   a. Mental illness means malfunction of the psychic apparatus that significantly interferes with ordinary living.
   b. Each person has a pattern of adjustment to life. The pattern of adjustment before the industrial injury or occupational disease serves as a baseline for all assessments of whether there has been a permanent impairment due to the industrial injury or occupational disease.
   c. To determine the pre-injury pattern of adjustment, all evaluations of mental health shall contain a complete pre-injury history including, but not necessarily limited to: Family background and the relationships with parents or other nurturing figures; extent of education and reaction to it; military experience, if any; problems with civil authorities; any history of prolonged illness, and difficulty with recovery; any history of drug abuse or alcoholism; employment history, the extent of and reaction to responsibility, and relationships with others at work; capacity to make and retain friends; relationships with spouses and children; nature of daily activities, including recreation and hobbies; and lastly, some summary statement about the sources of the patient's self-esteem and sense of identity. Both strengths and vulnerabilities of the person

shall be included.

d. Differences in adjustment patterns before and after the industrial injury or occupational disease shall be described, and the report shall contain the examining physician's opinion as to whether any differences: 1) are the result of the industrial injury or occupational disease and its sequelae, in the sense they would not have occurred had there not been the industrial injury or occupational disease; 2) are permanent or temporary; 3) are more than the normal, self-correcting and expectable response to the stress of the industrial injury or occupational disease; 4) constitute an impairment psychosocially or physiologically; and 5) are susceptible to treatment, and, if so, what kind. The presence of any unrelated or coincidental mental impairment shall always be mentioned.

f. No classification of impairment shall be made for complaints where the quality of daily life does not differ substantially from the pre-injury pattern. A patient not currently employed may not engage in the same activities as when working, but the level and variety of his activities and zest for them shall distinguish the purely situational difference from cases of regression and withdrawal. In cases where some loss of use of body member is claimed, no category or impairment shall be assigned unless there are objective findings of physiologic regression or consistent evidence of altered adaptability.

g. The physician shall identify the schizoid, antisocial, inadequate, sociopathic, passive, hysterical, paranoid, or dependent personality types. Patients with these long-standing character disorders may show problem behavior that seems more related to current stress than it is, sometimes unconsciously insinuating themselves into difficult situations of which they complain. Emotional reactions to an injury and subsequent events must be carefully evaluated in these patients. It must be medically probable that such reactions are permanent before a category of impairment can be attributed to the injury; temporary reactions or preexisting psychopathology must be differentiated.

Categories (WAC 296-20-340)

Choose the category below which best describes the patient's impairment:

Category 1. Nervousness, irritability, worry or lack of motivation following an injury and commensurate with it and/or other situational responses to injury that do not alter significantly the life adjustment of the patient may be present.

Category 2.

- Any and all permanent worsening of preexisting personality traits or character disorders where aggravation of preexisting personality trait or character disorder is the major diagnosis;
- mild loss of insight, mildly deficient judgment, or rare difficulty in controlling behavior;
- anxiety with feelings of tension that occasionally limit activity;
- lack of energy or mild apathy with malaise;
- brief phobic reactions under usually avoidable conditions;
- mildly unusual and overly rigid responses that cause mild disturbance in personal or social adjustment;
- rare and usually self-limiting psycho-physiological reactions;
- episodic hysterical or conversion reactions with occasional self limiting losses of physical functions;
- a history of misinterpreted conversations or events, which is not a preoccupation;
- is aware of being absentminded, forgetful, thinking slowly occasionally or recognizes some unusual thoughts;
- mild behavior deviations not particularly disturbing to other;
- shows mild over-activity or depression;
- personal appearance is mildly unkempt.

Despite such features, productive activity is possible most of the time. If organicity is present, some difficulty may exist with orientation; language skills, comprehension, memory; judgment; capacity to make decisions; insight; or unusual social behavior; but the patient is able to carry out usual work day activities unassisted.

Category 3.

- Episodic loss of self-control with risk of causing damage to the community or self;
- moments of morbid apprehension;
- periodic depression that disturbs sleep and eating habits or causes loss of interest in usual daily activities but self-care is not a problem;
- fear motivated behavior causing mild interference with daily life;

- frequent emotogenic organ dysfunctions requiring treatment;
- obsessive-compulsive reactions which limit usual activity;
- periodic losses of physical function from hysterical or conversion reactions;
- disturbed perception in that patient does not always distinguish daydreams from reality;
- recognizes his/her fantasies about power and money are unusual and tends to keep them secret;
- thought disturbances cause patient to fear the presence of serious mental trouble;
- deviant social behavior can be controlled on request;
- exhibits periodic lack of appropriate emotional control;
- mild disturbance from organic brain disease such that a few work day activities require supervision.

Category 4.

- Very poor judgment, marked apprehension with startle reactions, foreboding leading to indecision, fear of being alone and/or insomnia;
- some psychomotor retardation or suicidal preoccupation;
- fear-motivated behavior causing moderate interference with daily life;
- frequently recurrent and disruptive organ dysfunction with pathology of organ or tissues;
- obsessive-compulsive reactions causing inability to work with others or adapt;
- episodic losses of physical function from hysterical or conversion reactions lasting longer than several weeks;
- misperceptions including sense of persecution or grandiosity which may cause domineering, irritable or suspicious behavior;
- thought disturbance causing memory loss that interferes with work or recreation;
- periods of confusion or vivid daydreams that cause withdrawal or reverie;
- deviations in social behavior which cause concern to others;
- lack of emotional control that is a nuisance to family and associates;
- moderate disturbance from organic brain disease such as to require a moderate amount of supervision and direction of work day activities.

Category 5.

- Marked apprehension so as to interfere with memory and concentration and/or to disturb markedly personal relationships;
- depression causing marked loss of interest in daily activities, loss of weight, unkempt appearance, marked psychomotor retardation, suicidal preoccupation or disruptive behavior;
- psychophysiological reactions resulting in lasting organ or tissue damage;
- obsessive-compulsive reactions that preclude patient's usual activity;
- frequent or persistent loss of function from conversion or hysterical reactions with regressive tissue or organ change;
- defects in perception including frank illusions or hallucinations occupying much of the patient's time;
- behavior deviations so marked as to interfere seriously with the physical or mental well-being or activities of others;
- lack of emotional control including marked irritability or over activity.

Respiratory and Air Passages

A. Respiratory

Rules–For claims with a date of injury before March 1, 1994 (WAC 296-20-370)

(1) Rules for evaluation of permanent respiratory impairments:

(a) All reports of physical examination of persons for respiratory impairment shall include: Date of examination, name, sex, address, birth date, marital status, and occupation of the person being examined; height, weight, temperature, pulse rate, blood pressure and respiratory rate and physical findings on inspection, palpation, percussion, and auscultation, vital capacity tests including one-second forced expiratory volume, forced vital capacity and maximum voluntary ventilation; all symptoms such as wheeze, cough, orthopnea, chest pain, paroxysmal nocturnal dyspnea, expectoration, hemoptysis, as to date of onset, course with descriptions, variation, whether influenced by bodily activity, emotional stress, posture,

allergens, immediate environmental factors, medications, frequency and duration, and how they are affected by respiratory infections; the history of the particular exposure, a history of any previous chest x-rays, any allergies, cardiac symptoms or diagnosis, chest surgery or deformities, trauma, or other conditions such as pneumothorax, pulmonary infarct or chemical bronchitis; all pertinent personal history of habits such as smoking, weight gain or loss, fatigability, appetite; use of medications such as steroids, digitalis, antibiotics, bronchodilators, expectorants, etc., and occupational history.

(b) Categories 2 through 6 in WAC 296-20-380 include the presence of complaints of whatever degree.

(c) Dyspnea is the major complaint of respiratory impairment, and can usually be explained by the presence of abnormal lung ventilation, perfusion, or diffusion, measured either at rest or exercise. Since mechanisms of respiratory tract damage may differ widely, individual lung functions tests may not wholly correspond to the following categories of impairment, but the examining physician should be able to categorize the vast majority of persons, using a "best fit" method for the following respiratory impairment Categories I through VI.

(d) Persisting variable respiratory impairment due to allergic or irritative disorders or the respiratory tract, such as bronchial asthma or reactive airway disease, caused or substantially aggravated by factors in the work place, shall be evaluated by detailed narrative report, including rationale for the work relationship, relative importance of nonwork-related co-factors, such as preexisting asthma, tobacco usage, or other personal habits, the need for regular medication to substantially improve or control the respiratory condition, and the prognosis. If tests of ventilatory function, done when the person is in clinical remission, are nearly normal (1) second forced expiratory volume 80 percent or greater of predicted, (2) an appropriate provocative bronchial challenge test should be done to demonstrate the presence of unusual respiratory sensitivity. When the respiratory condition (asthma or reactive airway disease) is thought to be permanent, but the degree of respiratory impairment varies, then the examining physician shall give an estimate of percentage of total bodily impairment, as per Rule 15 or WAC 296-20-220.

Rules—For claims with a date of injury on or after March 1, 1994 (WAC 296-20-370)

1. Rules for evaluation of permanent respiratory impairments:

   a. Definitions.

      i. "FEV1" means the forced expiratory volume in 1 second as measured by a spirometric test performed as described in the most current *American Thoracic Society Statement on Standardization of Spirometry*, and using equipment, methods of calibration, and techniques that meet American Thoracic Society (ATS) criteria including reproducibility. The measurement used must be taken from a spirogram which is technically acceptable and represents the patient's best effort. The measurement is to be expressed as both an absolute value and as a percentage of the predicted value. The predicted values are those listed in the most current edition of the *American Medical Association (AMA) Guidelines* for rating permanent respiratory impairment.

      ii. "FVC" means the forced vital capacity as measured by a spirometric test in accordance with criteria described in (a)(i) of this subsection.

      iii. "FEV1/FVC" is a ratio calculated based on the ATS Guides criteria as described in the most current American Thoracic Society Statement on Standardization of Spirometry.

      iv. "Significant improvement" means a fifteen percent or greater improvement in FEV1 (volume) after a post-bronchodilator pulmonary function test.

      v. "DLCO" means the diffusion capacity of carbon monoxide as measured by a test based on predicted values demonstrated to be appropriate to the techniques and equipment of the laboratory performing the test according to current ATS standards. DLCO may be considered for impairment rating only if accompanied by evidence of impaired gas exchange based on exercise testing.

      vi. "VO2 Max" means the directly measured oxygen consumption at maximum exercise capacity of an individual as measured by exercise testing and oxygen consumption expressed in ml/kilo/min corrected for lean body-weight. Estimated values from treadmill or other exercise tests without direct measurement are not acceptable. The factor limiting the exercise must be identified.

vii. "Preexisting impairment" shall be reported as described in WAC 296-20-220 (l)(h).

viii. "Coexisting" is a disease or injury not due to or causally related to the work-related condition that impacts the overall respiratory disability.

ix. "Apportionment" is an estimate of the degree of impairment due to the occupational injury/exposure when preexisting or coexisting conditions are present.

x. "Dyspnea" is the subjective complaint of shortness of breath. Dyspnea alone must not be used to determine the level of respiratory impairment. Dyspnea unexplained by objective signs of impairment of spirometry requires more extensive testing (i.e., VO2 Max).

xi. Copies of the *American Thoracic Society Statement on Standardization of Spirometry* and ATS standards for measuring DLCO can be obtained by ordering P*ulmonary Function Testing* from The American Thoracic Society, 17640 Broadway, New York, NY 10019-4374, Attn: ATS Statements. Copies of this document are available for review in the section of the Office of the Medical Director, Department of Labor & Industries, Tumwater building.

These standards are also available through the following references: "American Thoracic Society of Committee on Proficiency Standards for Pulmonary Function Laboratories: Standardization of Spirometry-1987 update." *Am Rev Respir Dis* 1987; 136:1285-1298. "American Thoracic Society DLCO Standardization Conference: Single breath carbon monoxide diffusing capacity (transfer factor): Recommendations for a standard technique." *Am Rev Respir Dis* 1987; 136: 1299-13707.

b. Evaluation procedures. Each report of examination must include the following, at a minimum:

i. Identification data: Worker's name, claim number, gender, age, and race.

ii. Detailed occupational history: Job titles of all jobs held since employment began. A detailed description of typical job duties, protective equipment worn, engineering controls present (e.g., ventilation) as well as the specific exposures and intensity (frequency and duration) of exposures. More detail is required for jobs involving potential exposure to known respiratory hazards.

iii. History of the present illness: Chief complaint and description of all respiratory symptoms present (e.g., wheezing, cough, phlegm, chest pain, paroxysmal nocturnal dyspnea, dyspnea at rest and on exertion) as well as the approximate date of onset, and duration of each symptom, and aggravating and relieving factors.

iv. Past medical history: Past history of childhood or adult respiratory illness, hay fever, asthma, bronchitis, chest injury, chest surgery, respiratory infections, cardiac problems, hospitalizations for chest or breathing problems and current medications.

v. Lifestyle and environmental exposures: Descriptive history of exposures clinically related to respiratory disease including, but not limited to, tobacco use with type and years smoked. Use of wood as a primary heat source at home or hobbies that involve potential exposure to known respiratory tract hazards, and other environmental exposures.

vi. Family history: Family history of respiratory or cardiac disease.

vii. Physical examination findings: Vital signs including a measured height without shoes, weight, and blood pressure. Chest exam shall include a description of the shape, breathing, breath sounds, cardiac exam, and condition of extremities (e.g., cyanosis, clubbing, or edema).

viii. Diagnostic tests: A chest x-ray shall be obtained in all cases. When available, the x-ray should be obtained using International Labor Organization (ILO) standard techniques and interpreted using the ILO classification system. The presence or absence of pleural thickening or interstitial abnormalities shall be noted. Also include pulmonary function reports including a description of equipment used, method of calibration, and the predicted values used. A hard copy of all pulmonary functions tracings must be available for review. The report must contain a minimum FEV1 and FVC and a narrative summary of an interpretation of the test results and their validity.

ix. The rating of respiratory impairment. The rating of respiratory impairment shall be based on the pulmonary function test most appropriate to the respiratory condition. A prebronchodilator and postbronchodilator test must be performed on and results reported for all patients with demonstrated

airway obstruction. The largest FEV1 of FVC, on either the prebronchodilator or postbronchodilator trial must be used for the rating impairment. If the FEV1 and FEV1/FVC result in different categories of impairment, the value resulting in a higher category on impairment will be used.

x. The rating of persisting variable respiratory impairment with abnormal baseline function. If resting FEV1 is "abnormal" (below eighty percent predicted) and shows significant bronchodilator improvement (a greater than or equal to fifteen percent improvement in FEV1) one category of impairment must be added to the given category rating, but only when the work-related disease being rated is obstructive in nature. If there is substantial variability from test to test (and good effort) the severity of impairment may be rated, using the best fit into the category system, as described in WAC 296-20-380.

xi. The rating of persisting variable respiratory impairment with normal baseline spirometry. Variable respiratory impairment due to allergic or irritative disorder of the respiratory tract, such as bronchial asthma or reactive airway disease, caused or permanently aggravated by factors in the work place, shall be evaluated by detailed narrative report, including the causal relationship to work factors, a discussion of the relative importance of nonwork related cofactors, such as preexisting asthma, tobacco usage, or other personal habits, the need for regular medication to substantially improve or control the respiratory condition, and the prognosis. When tests of ventilatory function, done when the patient is in a clinical steady state, are normal (one second forced expiratory volume eighty percent or greater if predicted), an appropriate provocative bronchial challenge test (i.e., methacholine or histamine) shall be done to demonstrate the presence of unusual respiratory sensitivity.

xii. At the time of the rating, the patient shall be off theophylline for at least twenty-four hours, beta agonists for at least twelve hours, and oral and/or inhaled steroids or cromolyn for at least two weeks, in order to determine severity of air-flow obstruction, unattenuated by therapy. If withdrawal of medication would produce a hazardous or life threatening condition, then the impairment cannot be rated at this time, and the physician must provide a statement describing the patient's condition and the effect of medication withdrawal.

xiii. The method for standardizing provocative bronchial challenge testing, using either histamine or methacholine, shall be used. The test drug may be given either by continuous tidal volume inhalation of known concentrations, using an updraft nebulizer, for two minutes, or by the technique of intermittent deep breaths of increasing test drug strengths either via a Rosenthal dosimeter or updraft nebulizer, and the results shall be expressed either as the mg/ml concentration of test drug, or the cumulative breath units (1 breath of a 1 mg/ml solution equals one breath unit) which result in a prompt and sustained (at least three minute) fall in the FEV1, greater than twenty percent below baseline FEV1. Medications that can blunt the effect of bronchoprovocation testing shall be withheld prior to testing. Once testing is complete, the results shall be expressed in terms of normal, mild, moderate, or marked bronchial reactivity, as described in WAC 296-20-385.

If multiple bronchoprocative inhalation challenge tests have been done, the examining physician shall select the one category (normal, mild, moderate, or marked) which most accurately indicates the overall degree of permanent impairment at the time of rating.

If the results of serial pulmonary function testing are extremely variable and the clinical course and use of medication also indicate major impairment, then the physician must make a statement in the formulation and medical evaluation containing, at a minimum: Diagnosis and whether work-related or nonwork-related; nature and frequency of treatment; stability of condition and work limitations; impairment.

xiv. Further treatment needs. In all cases, the examining physician shall indicate whether further treatment is indicated and the nature, type, frequency, and duration of treatment recommended.

Categories of permanent respiratory impairments – For Claims with a date of injury before March 1, 1994 (WAC 296-20-380)

Category 1. Tests of ventilatory functions are not less than 85 percent of predicted normal for the person's age, sex and height. Arterial

oxygen saturation at rest and after exercise is 93 percent or greater. Subjective complaints may be present or absent.

Category 2. Tests of ventilatory function range from 70 to 85 percent of predicted normal for the person's age, sex and height. Arterial oxygen saturation at rest and after exercise is 93 percent or greater. Dyspnea consistent with ventilatory function and arterial oxygen saturation.

Category 3. Tests of ventilatory function range from 60 to 70 percent of predicted normal for the person's age, sex and height and/or arterial oxygen saturation at rest is normal but after exercise is 88 to 93 percent. Dyspnea consistent with ventilatory function and arterial oxygen saturation.

Category 4. Tests of ventilatory function range from 50 to 60 percent of predicted normal for the person's age, sex and height. Arterial oxygen saturation at rest and after exercise is 88 to 93 percent. The single breath diffusing capacity (if performed) is greater than 50 percent predicted. Dyspnea consistent with ventilatory function and arterial oxygen saturation.

Category 5. Tests of ventilatory function range from 40 to 50 percent of predicted normal for the person's age, sex and height. Arterial oxygen saturation at rest and after exercise is less than 88 percent. The single breath diffusing capacity is greater than 40 percent predicted. Dyspnea consistent with ventilatory function and arterial oxygen saturation.

Section V

Category 6. Tests of ventilatory function are below 40 percent of predicted normal for the person's age, sex and height. Arterial oxygen saturation at either rest or exercise is less 83 percent or less. The single breath diffusing capacity is 40 percent or less of predicted. Grade III or IV dyspnea is present, measured on a scale of 0 to 4.

Categories of permanent respiratory impairments – For claims with a date of injury on or after March 1, 1994 (WAC 296-20-380)

Choose the category below which best describes the patient's impairment:

Category 1. The FVC and FEV1 are greater than or equal to eighty percent of predicted normal for the person's age, sex and height. The FEV1/FVC ratio is greater than or equal to .70. Subjective complaints may be present or absent. If exercise testing is done, the maximum oxygen consumption is greater than 25cc/kilo/min.

Category 2. The FVC or FEV1 is from seventy to seventy-nine percent of predicted, and if obstruction is present, the FEV1/FVC ratio is .60-.69. If exercise testing is done, the maximum oxygen consumption is 22.5-25cc/kilo/min.

Category 3. The FVC or FEV1 is from sixty to sixty-nine percent of predicted, and if obstruction is present, the FEV1/FVC ratio is .60-.69. If exercise testing is done, the maximum oxygen consumption is 20-22.4cc/kilo/min.

Category 4. The FVC or FEV1 is from fifty-one to fifty-nine percent of predicted. The FEV1/FVC ratio is .51-.59. If exercise testing is done, the maximum oxygen consumption is 17.5-19.9cc/kilo/min.

Category 5. FVC from fifty-one to fifty-nine percent of predicted, or the FEV1 from forty-one to fifty percent of predicted, and if obstruction is present, the FEV1/FVC ratio is .41-.50. If exercise testing is done, the maximum oxygen consumption is 15-17.4cc/kilo/min.

Category 6. The FVC is equal to or less than fifty percent of predicted or the FEV1 is equal to or less than forty percent of predicted. The FEV1/FVC ratio is equal to or less than .40. If exercise testing is done, the maximum oxygen consumption is less than 15cc/kilo/min.

Categories of persisting variable respiratory impairment with normal baseline spirometry– for claims with a date of injury on or after March 1, 1994 (WAC 296-20-385)

Choose the category below which best describes the patient's impairment:

Category 1. "Normal" bronchial reactivity is demonstrated by an insignificant (less than twenty percent) fall from baseline FEV1 at test doses of histamine or methacholine, up to 16mg/ml (continuous inhalation method) or up to 160 breath units (cumulative, repeated deep breath technique).

Category 2. "Mild" bronchial hyperactivity (BHR) is a significant (equal to or greater than twenty percent) fall in the FEV1 at test doses of 2.1-16-mg/ml, or 21-160 breath units.

Category 3. "Moderate" BHR is a significant (equal to or greater than twenty percent) fall in the FEV1 at test doses of 0.26-2-mg/ml, or 2.6-

20 breath units.

Category 4. "Marked" BHR is a significant (equal to or greater than twenty percent) fall in FEV1 at test doses equal to or less than .25 mg/ml, or 2.5 breath units.

B. Air Passages

Rules (WAC 296-20-390)

(1) Rule for evaluation of permanent air passage impairments:

(a) Categories 2, 3, 4 and 5 include the presence of complaints of whatever degree.

Categories (WAC 296-20-400)

Choose the category below which best describes the patient's impairment:

Category 1. No objective findings are present. Subjective complaints may be present or absent.

Category 2. Objective findings of one or more of the following air passage defects: partial obstruction of oropharynx, laryngopharynx, larynx, trachea, bronchi, complete obstruction of nasopharynx or of nasal passages bilaterally. No dyspnea caused by the air passage defect even on activity requiring prolonged exertion or intensive effort.

Category 3. Objective findings of one or more of the following air passage defects: partial obstruction of oropharynx, laryngopharynx, larynx, trachea, bronchi, complete obstruction of nasopharynx or of nasal passages bilaterally, dyspnea caused by the air passage defect produced only by prolonged exertion or intensive effort.

Category 4. Objective findings of one or more of the following air passage defects: partial obstruction of oropharynx, laryngopharynx, larynx, trachea, bronchi, complete obstruction of nasopharynx or of nasal passages bilaterally, with permanent tracheostomy or stoma, dyspnea caused by the air passage defect produced only by prolonged exertion or intensive effort.

Category 5. Objective findings of one or more of the following air passage defects: partial obstruction of oropharynx, laryngopharynx, larynx, trachea, bronchi, with or without permanent tracheostomy or stoma if dyspnea is produced by moderate exertion.

Category 6. Objective findings of one or more of the following air passage defects: partial obstruction of oropharynx, laryngopharynx, larynx, trachea, bronchi, with or without permanent tracheostomy or stoma if dyspnea is produced by mild exertion.

C. Nasal Septum Perforations

Rules (WAC 296-20-410)

(1) Rules for evaluation of permanent air passage impairments due to nasal septum perforation.

(a) These categories, if appropriate, are to be used in addition to the Categories of Permanent Air Passage Impairment.

(b) Categories 1 and 2 include complaints of whatever degree.

Categories (WAC 296-20-420)

Choose the category below which best describes the patient's impairment:

Category 1. Perforation or perforations posterior to the cartilaginous septum.

Category2. Perforation or perforations through or anterior to the cartilaginous septum.

D. Chronic Sinusitis

The AMA *Guides* should be used for rating of impairment from chronic sinusitis.

Skin

Rules (WAC 296-20-470)

1. Rules for evaluation of permanent skin impairments.

a. Evaluation of permanent impairment of the skin shall be based upon actual loss of function and cosmetic factors shall not be considered.

b. Categories 2, 3, 4, 5 and 6 include the presence of complaints of whatever degree.

Categories (WAC 296-20-480)

Choose the category below which best describes the patient's impairment:

Category 1. Objective findings of skin disorder may be present or absent but there is no, or minimal limitation in daily activities. Subjective complaints may be present or absent.

Category 2. Objective findings of skin disorder are present and there is discomfort and minimal limitation in the performance of daily activities.

Category 3. Objective findings of skin disorder are

present and there is limitation in some daily activities, including avoidance of and protective measures against certain chemical or physical agents. Intermittent symptomatic treatment is required.

Category 4. Objective findings of skin disorders are present and there is limitation in many daily activities, including avoidance of and protective measures against certain chemical or physical agents. Continuous symptomatic treatment is required.

Category 5. Objective findings of skin disorder are present and there is limitation in most daily activities, including avoidance of and protective measures against certain chemical or physical agents. Continuous symptomatic treatment is required.

Category 6. Objective findings of skin disorder are present and there is limitation in all daily activities, including avoidance of and protective measures against certain chemical or physical agents. Continuous symptomatic treatment is required.

Speech

Rules (WAC 296-20-450)

1. Rules for evaluation of permanent speech impairments.
   a. The physician making an examination for evaluation of permanent speech impairment should have normal hearing and the examination should be conducted in a reasonably quiet office which approximates the noise level conditions of everyday living.
   b. Selection of the appropriate category of permanent speech impairment shall be based on direct observation of the speech of the person being examined, including, but not limited to: response to interview, oral reading, and counting aloud. The observation shall be made with the physician about eight feet from the person being examined both when he faces the physician and with his back to the physician.

Categories (WAC 296-20-460)

Choose the category below which best describes the patient's impairment:

Category 1. No objective findings of significant speech impairments are present. Subjective complaints may be present or absent.

Category 2. Can produce speech of sufficient audibility, intelligibility and functional efficiency for most everyday needs, although this may require effort and occasionally exceed capacity; listeners may occasionally ask for repetition and it may be difficult to produce some elements of speech, and there may be slow speaking and hesitation.

Category 3. Can produce speech of sufficient audibility, intelligibility and functional efficiency for many everyday needs, is usually heard under average conditions but may have difficulty in automobiles, busses, trains, or enclosed areas; can give name, address, and be understood by a stranger, but may have numerous inaccuracies and have difficulty articulating; speech may be interrupted, hesitant or slow.

Category 4. Can produce speech of sufficient audibility, intelligibility and functional efficiency for some everyday needs such as close conversation, conversation with family and friends, but has considerable difficulty in noisy places; voice tires rapidly and tends to become inaudible in a few seconds, strangers may find patient difficult to understand; patient may be asked to repeat often, and often can only sustain consecutive speech for brief periods.

Category 5. Can produce speech of sufficient audibility, intelligibility and functional efficiency for few everyday needs; can barely be heard by a close listener or over the telephone; may be able to whisper audibly but has no voice; can produce some speech elements; may have approximation of a few words such as names of family members which are, however, unintelligible out of context; cannot maintain uninterrupted speech flow, speech is labored, and its rate is impractically slow.

Category 6. Is unable to produce speech of sufficient audibility, intelligibility and functional efficiency for any everyday needs.

Taste and Smell

Rules (WAC 296-20-430)

1. Rule for evaluation of permanent loss of taste and smell.
   a. If the person being examined can detect any odor or taste, even though it cannot be named, no category shall be assigned.

Categories (WAC 296-20-440)

Choose the category below which best describes the patient's impairment:

Category 1. Loss of sense of taste.

Category 2. Loss of sense of smell.

Urologic

A. Spleen, Loss of One Kidney and Surgical Removal of Bladder with Urinary Diversion

Rules (WAC 296-20-570)

(1) Rule for evaluation of permanent impairments of the spleen, loss of one kidney, and surgical of bladder with urinary diversion.
   (a) Categories 1, 2 and 3 include complaints of whatever degree.

Categories (WAC 296-20-580)

Choose the category below which best describes the patient's impairment:

Category 1. Loss of spleen by splenectomy after age eight.

Category 2. Loss of one kidney by surgery or complete loss of function of one kidney.

Category 3. Surgical removal of bladder with urinary diversion.

B. Upper Urinary Tract

Rules (WAC 296-20-590)

(1) Rule for evaluation of permanent impairment of upper urinary tract.
   (a) Categories 2, 3, 4 and 5 include the presence of complaints of whatever nature.

Categories (WAC 296-20-600)

Choose the category below which best describes the patient's impairment:

Category 1. No objective findings of impairment of the upper urinary tract. Subjective complaints may be present or absent.

Category 2. Loss of upper urinary function as evidenced by creatinine clearance of 75 to 90 liters/24 hr (52 to 62.5 ml/min) and PSP excretion of 15 percent to 20 percent in 15 minutes; or if there are intermittent objective findings of upper urinary tract disease or dysfunction not requiring continuous treatment or surveillance.

Category 3. Loss of upper urinary tract function as evidenced by creatinine clearance of 60 to 75 liters/24 hr (42 to 52 ml/min) and PSP excretion of 10 percent to 15 percent in 15 minutes; or although function is greater than test levels, there are objective findings of upper urinary tract disease or dysfunction requiring continuous surveillance and frequent symptomatic treatment.

Category 4. Loss of upper urinary tract function as evidenced by creatinine clearance of 40 to 60 liters/24 hr (28 to 42 ml/min) and PSP excretion of 5 percent to 10 percent in 15 minutes; or although function is greater than these levels, there are objective findings of mild or moderate upper urinary tract disease or dysfunction which can be only partially controlled.

Category 5. Loss of upper urinary tract function as evidenced by creatinine clearance below 40 liters/24 hr (28 ml/min) and PSP excretion below 5 percent in 15 minutes; or although function is greater than these levels there are objective findings of severe upper urinary tract disease or dysfunction which persists despite continuous treatment.

C. Upper Urinary Tract (due to surgical diversion)

Rules (WAC 296-20-610)

(1) Rule for evaluation of additional permanent impairments of upper urinary tract due to surgical diversion.
   (a) These categories include the presence of complaints of whatever degree.

Categories (WAC 296-20-620)

Choose the category below which best describes the patient's impairment:

Category 1. Uretero-intestinal diversion of cutaneous ureterostomy without intubation.

Category 2. Nephrostomy or intubated ureterostomy.

D. Bladder

Rules (WAC 296-20-630)

(1) Rules for evaluation of permanent impairment of bladder function.

(a) In making examinations for evaluation of impairments of bladder function, physicians shall use objective techniques including, but not limited to, cystoscopy, cystography, voiding cystourethrography, cystometry, uroflometry, urinalysis and urine culture.

(b) Categories 2, 3, 4 and 5 include the presence of complaints of whatever degree.

Categories (WAC 296-20-640)

Choose the category below which best describes the patient's impairment:

Category 1. No objective findings are present. Subjective complaints may be present or absent.

Category 2. Objective findings of bladder dysfunction, intermittent treatment required, but there is no dysfunction between such intermittent attacks.

Category 3. Objective findings of bladder dysfunction, continuous treatment required or there is good bladder reflex activity but no voluntary control.

Category 4. Objective findings of bladder dysfunction, there is poor reflex activity with intermittent dribbling and no voluntary control.

Category 5. Objective findings of bladder dysfunction, there is no reflex or voluntary control and there is continuous dribbling.

E. Testicular

Rules (296-20-650)

(1) Rule for evaluation of permanent anatomical or functional loss of testes.

(a) Categories 2, 3, 4 and 5 include the presence of whatever complaints.

Categories (WAC 296-20-660)

Choose the category below which best describes the patient's impairment:

Category 1. No objective findings. Subjective complaints may be present or absent.

Category 2. Anatomical or functional loss of one testicle.

Category 3. Anatomical or functional loss of both testes after the age of 65.

Category 4. Anatomical or functional loss of both testes between the ages of 40 and 65.

Category 5. Anatomical or functional loss of both testes before the age of 40.

Visual System

Partial loss of vision is rated as a percentage of complete loss of vision in each eye. When evaluating vision, please provide central visual acuity data in your report. Describe the worker's condition without correction. Give treatment recommendations, if correction is indicated. To rate vision, refer to the most recent edition of the AMA *Guides*. PLEASE NOTE: Although the AMA *Guides* has instructed examiners to use corrected visual acuities for the rating, RCW 51.36.020 requires that the rating of visual impairment be based on the loss of sight before correction. Therefore, examiners should use uncorrected visual acuities for the rating.

Complete loss of vision in an eye is reported as: (1) Loss of one eye by enucleation, or (2) Loss of central visual acuity in one eye. See RCW 51.32.080, Permanent partial disability, miscellaneous, Appendix C-1.

For other WACs not cited in the sections above, please refer to Appendix C.

Section VI:

General Information about Billing

Where can I find billing codes and fees?

Provider Bulletin Number 04-07 describes the revised IME fees, effective for dates of service beginning July 1, 2004. You can find this bulletin and all subsequent Provider Bulletins on the Internet at www.LNI.wa.gov/ClaimsInsurance/Providers under "Billing & Payment." If you need hard copies of the Provider Bulletins or the CMS/500 (formerly HCFA 1500) Billing Instructions, you may request them from the Provider Hotline at 1-800-848-0811.

Beginning July 2005, you may find this information in the Medical Aid Rules and Fee Schedules. It is updated annually. The current full document is available at the following web site address: www.LNI.wa.gov/claimsinsurance/providerpay/feeschedules.

You may order a CD of the Medical Aid Rules and Fee Schedules. Order information is available at the following web site address:

www.LNI.wa.gov/claimsIns/Providers/default.asp

To order a CD by phone, call the Labor & Industries Warehouse and ask for Item number F245-094-034 at 360-902-5753.

Appendix A:

Application procedure for IME examiners, IME firms

Application Process

The Washington State Department of Labor and Industries (L&I) is responsible for assuring that only qualified and approved examiners conduct examinations for the State Fund, Self-Insured and Crime Victims' programs. Only doctors who are licensed in medicine and surgery, osteopathic medicine and surgery, chiropractic, podiatric medicine and surgery, and dentistry are eligible to apply to become approved examiners.

To apply for approval as an independent medical examiner, you need to complete and sign the IME Provider Account Application. The information on the application also allows schedulers to match the specialist's expertise with the worker's injury.

See the web site for the application and additional instructions: www.LNI.wa.gov/Forms

Requirements for approved IME examiners

If you are licensed to practice medicine and surgery, osteopathic medicine and surgery, podiatric medicine and surgery, or dentistry, you must meet one of the two following requirements:

1) Board certification in your specialty;
2) Full-time or part-time (average of eight hours or more per week in the past two years) active practice involving direct patient care in your medical specialty, excluding IMEs.

Chiropractic If you are licensed to practice chiropractic, you must meet **three** requirements:

- Be a chiropractic consultant for L&I for at least two years;
- Take an impairment rating course approved by L&I; and
- Attend L&I's chiropractic consultant or examiners' seminar during the 24 months prior to sending in your application.

In order to become a chiropractic consultant for L&I, you must have a current practice in Washington. Contact the Provider Review and Education Unit, PO Box 44322, Olympia, WA 98504-4322 or call (360) 902-6817 for application information. Minimum requirements for becoming a chiropractic consultant include the following:

- Maintain a current license to practice chiropractic in the State of Washington.
- Have an active provider number with L&I.
- Provide proof of completing not fewer than 180 hours of post-graduate continuing education prior to application.
- Maintain an active clinical practice for a minimum of five years with at least two years in Washington. At least 50 percent of the practice in Washington must be devoted to patient management (direct patient care), including treatment of workers.
- Demonstrate a pattern of practice within the department's utilization standards and Medical Aid Rules and Fee Schedules.
- Attend the department's chiropratic consultant and basic workers' compensation seminars.

After completing two years as a chiropractic consultant, you may apply to become an independent medical examiner.

Review of applications

If the department approves your application, we will enter the information you supply into the approved examiners database.

If we need more information, we will return your application with a letter, describing the areas that you need to complete. If we approve or deny your application, the Provider Review and Education Unit will notify you.

The department's medical director considers many factors in disapproving an application, such as the following:

- Any actin against provider's license
- Complaints about the provider;
- Quality of reports;
- Late reports;
- Charges regarding any crime, gross misdemeanor, felony or violation of statutes or rules by any administrative agency, court or board; and/or
- Convictions of any crime, gross misdemeanor, felony or violation of statutes or rules by any administrative agency, court or board. [WAC 296-23-327]

If you have questions about the Approved Examiner Application, contact the Provider Review and Education Unit at 360-902-6815.

Requirements for IME firm providers

Firms (panels) are organizations that provide examinations by one or more examiners. Information on starting an IME firm is available from L&I's Provider Review and Education Unit, PO Box 44322, Olympia, WA 98504-4322.

The department must have approved and issued a unique provider number to an IME firm so that it can bill for IME services.

In order to have a department-assigned IME provider number, an IME firm, partnership, corporation or other legal group must have a medical director. The medical director must be a licensed provider and be responsible to provide oversight on the quality of independent medical examinations, impairment ratings and reports. [WAC 296-23-312 (5) (e)]

Firms must meet certain business requirements and site standards. See Page II 2, 3 for details.

IME firms may send copies of professional licenses and signed IME Provider Account Applications for the doctors who work for them to the Provider Review and Education Unit.

IME firms must maintain billing records and reports with supporting documentation for a minimum of five years for audit purposes. [WAC 296-20-02005]

Important to Know

The department does not guarantee referrals to any specific IME approved providers and providers are not obligated to accept any IME assignments.

All IME providers must notify L&I's Provider Review and Education Unit of any changes in their qualifications or other information, such as address, exam sites, etc.

To make sure our information is current, you can query and view your information on the department's IME approved examiner database at this website: www.imes.LNI.wa.gov. Click on "Find a Medical Examiner."

If your information has changed or is not correct, please contact:

Department of Labor & Industries
Provider Review and Education Unit
PO Box 44322
Olympia, WA 98504-4322
FAX: 360-902-4249

For further details on the topics included in Appendix A, see pages II 1-7 in the text.

Appendix B
Sample Reports and Forms

Sample reports and forms: Which form do I use?

This appendix presents templates of reports you should follow to make sure your report includes all required information.

Please be sure to refer to other portions of this handbook for more information. In particular, please note that Section V, Part Two, includes worksheets for cervical and cervico-dorsal (V 10-V 11), lumbar and lumbo-sacral (V 20-V 21), and hearing loss impairment rating (V 30-V 31).

Sample Report	Use this format if you are:	Page
#1: Required Content of IME report	Approved IME examiners, when requested by Claim Manager	B 2-6
#2: "Impairment rating only" IME	Approved IME examiners, consultants*	B 7-8
#3: Attending Doctor impairment rating	Attending Doctors authorized to rate impairment and requested by Claim Manager	B 9
#4: Impairment rating, example of "lighting up" in previously asymptomatic worker	Attending doctors, IME examiners, consultants	B 9
#5: Impairment rating, example of "lighting up" in previously symptomatic worker	Attending doctors, IME examiners, consultants	B 10
#6: Doctor's Assessment of Work-Relatedness for Occupational Diseases Occupational Disease Work History Form	Attending doctors, IME examiners, consultants Worker fills out this form. Examining doctor reviews it with worker to complete Doctor's Assessment of Work-Relatedness for Occupational Diseases	B 10-16
#7: Doctor's Estimate of Physical Capacities	Attending doctors, IME examiners, consultants, if requested	B 17

* Note regarding consultants: The referral source is the attending doctor who has been asked by the claim manager to perform an impairment rating. Attending doctors may not wish to perform the rating, but prefer to select a consultant.

Sample Report #1:
Required Content of IME Reports in Washington State Workers' Compensation

Department of LABOR AND INDUSTRIES

All elements are required in all IME reports except those marked by an asterisk. ✪ Elements marked by an asterisk should be included ONLY if specifically requested by the claim manager.

Please use this Sample Report as a "template" when you dictate your reports so you remember to include all the information required. Your transcriptionist may download the template from the L&I web page . See Item #12 inside the back cover of this handbook.

A. INTRODUCTION

The introduction should include explanations given to the worker about the purpose and procedures of the exam, a statement about who accompanied the claimant, and other general information about the exam.

B. HISTORY OF PRESENT INJURY

A history from the worker describing both the course of injury or treatment and his or her present status (to be reported separately and distinctly from the record review). The report should distinguish when events described are based on the worker's history alone.

C. CURRENT SYMPTOMS

When the worker describes pain, swelling or rash, be sure to elicit and report details such as location, distribution, effect on activities, etc.

See Pages III 1-2 for more information.

IDENTIFYING INFORMATION

Name:	John Smith	**Claim #:**	N100000
Address:	2424 Poplar Drive Seattle, WA 98100	**Date of injury:**	July 7, 2003
		Date of birth:	June 2, 1948

Employer at time of injury: ABC Lumber, Inc.

Date of examination: March 2, 2005

Location of examination: Seattle Clinic

Examiners: Tim Jones, M.D., Hand Surgeon (dictating)
Susan Barnes, M.D., Neurologist

INTRODUCTION

The opinions expressed in this report are those of the physicians and reflect agreement by both examining physicians on all conclusions, except where otherwise specified. The opinions do not reflect the opinions of XYZ Panel, Inc. Mr. Smith was informed that this examination was at the request of the Washington State Department of Labor and Industries (L&I). He was also informed that a written report would be sent to L&I and to his attending doctor, Dr. X, as requested in the assignment letter from the claim manager. Mr. Smith was also informed that the examination was for evaluative purposes only, intended to address specific injuries or conditions as outlined by L&I, and was not intended as a general medical examination.

Mr. Smith was asked at the time of the examination not to engage in any physical maneuvers beyond what he could tolerate, or which he felt were beyond his limits, or which could cause harm or injury.

Mr. Smith was an excellent historian. The historical portion of this report is being dictated in the presence of the claimant so that additions or corrections can be made if necessary.

Mr. Smith was accompanied by his friend, Sally Rogers, during the entire examination.

HISTORY FROM THE WORKER

Chief complaints:

1) Decreased strength in the dominant right hand
2) Tingling and numbness in the both hands.

History of present injury:

Mr. Smith is a 56-year-old greenchain puller at ABC Lumber. He has held this job for 20 years. He...

Current symptoms

At the time of today's exam, Mr. Smith reports moderate tingling and numbness in both hands, right greater than left. The distribution of the tingling is …. In the last few days the sensation has been getting worse, which he associates with …. He also reports decreased strength in his right hand. He denies pain in any part of either upper extremity ….

APPENDIX **B**

Sample Report #1:
Required Content of IME Reports in Washington State Workers' Compensation

As always, put the claim number in the top right corner of every page.

D. OCCUPATIONAL HISTORY
See "Occupational Diseases," page III 5-9 for the additional information required for occupational carpal tunnel syndrome, occupational hearing loss, and other work-related diseases. For occupational injuries, a brief occupational history will suffice.

E. CURRENT WORK STATUS
This is a statement from the worker about whether he or she is employed at the time of the examination, and if unemployed, why.

F. PAST MEDICAL HISTORY
This should include a medication history that documents a worker's current medications, past and present illicit drug use, if any, and pattern of alcohol and tobacco intake. A negative or positive history must be recorded. Confounding conditions (diabetes, etc.) should be addressed.

G. SOCIOECONOMIC HISTORY
This should include education, marital status and military experience.

H. REVIEW OF SYSTEMS
A review of systems is needed to determine if other illnesses or conditions are present.

I. RECORD REVIEW
The record review must provide a detailed chronology of the injury or condition including:
- Mechanism of injury or exposure.
- Diagnostic studies or results.
- Treatments and outcomes, including names of all practitioners involved in treatment.

Occupational history:
Since the diagnoses include an occupational disease (carpal tunnel syndrome), and because we have been requested by the claim manager to provide the Doctor's Assessment of Work-Relatedness for Occupational Diseases, we are attaching the requested report as an addendum.

Current work status:
Mr. Smith states he is not working at present because....

Past medical history:
Injuries: Lumbar strain, 1985
Illnesses: Pneumonia, 1982
Operations: Hernia repair, 1990
Hospitalizations: None
Allergies: No known allergies
Medications: None
Substance use:
- **Tobacco:** One pack per day for the last 20 years
- **Alcohol:** One beer per week; no history of DWIs or black-outs
- **Illicit drugs:** History of marijuana use over 25 years ago

Family history: Father with diabetes….

Socioeconomic history:
Marital status and dependents: Single; no dependents
Education: Finished 10th grade; GED.
Military: Served 4 years in the army 1966-70, honorable discharge with no service-connected disability.

Review of systems:
Non-contributory except mild depression for the last two months, without suicidal ideation, weight loss, insomnia or other....

RECORD REVIEW

The chart has been reviewed in detail. Records reviewed and pertinent data from those records include the following:

- Chart notes of Brian Johnson, M.D., Family Practice, from 7/28/02 through 3/3/04.
  7/28/02: Dr. Johnson saw Mr. Smith for the first time. Chief complaint at that visit was low back pain. Examination revealed normal neurologic exam, ...Lumbo-sacral spine x-rays revealed....
  8/7/02: Mr. Smith reported substantial improvement in his symptoms with conservative care.....
- Chart notes of Mary Miller, D.O., Neurologist, from 9/5/00 through 11/4/01.
  9/5/00: Dr. Miller saw Mr. Smith for the first time. She reported a normal neurologic exam....
- Electrodiagnostic report of William Jones, M.D., Neurologist, performed on 1/3/05.
  EMG revealed.....

Significant missing records included those of the most recent clinical visits and an electrodiagnostic report referenced in the chart notes of Dr. Johnson on 11/3/03.

Sample Report #1:
Required Content of IME Reports in Washington State Workers' Compensation

J. PHYSICAL EXAMINATION

Please give sufficient detail of both positive and negative findings to support examination conclusions. This will establish a record that you may be asked to discuss in the future. Non-organic signs (such as Waddell's signs) should be reported when appropriate. When swelling, rash, or abnormal range of motion are observed, be sure to report details such as location, distribution, character, etc. Goniometric measurement of ROM is not required but may be helpful.

See Page III 1-2 for more information.

K. MULTIPLE EXAMINATIONS

For IMEs with multiple examiners, each specialty should report physical exam findings separately (orthopedic exam, neurologic exam, etc.).

L. DIAGNOSTIC STUDIES

If diagnostic testing is needed to complete the examination, please arrange for the needed test, then complete the report. Invasive testing (myelogram, biopsies, etc.) should be referred back to the attending doctor. Opinions on testing should, as much as possible, be consistent with guidelines established by the department.

See Guidelines, Pages III 3-4 for more information.

N. ACCEPTED CONDITIONS

You should simply repeat exactly the accepted conditions in the assignment letter. This is for administrative purposes, since the accepted conditions may differ from your diagnoses.

O. DIAGNOSES AND WORK-RELATEDNESS

Specific diagnoses must be presented in the way listed below.

Diagnoses. Give a brief, one-line statement of each diagnosis.

Pre-existing conditions. State whether they are worsening on their own or as a result of the accepted condition.

(See Pre-existing Conditions, Pages V 4-6.)

March 2, 2005
John Smith, Claim # N100000
Page 3 of 5

PHYSICAL EXAMINATION

Vital signs: Height: 6' 1". Weight: 240 pounds. Blood pressure: 130/76. Pulse: 88 and regular. Temperature: 98.6. Dominant hand: right.

ORTHOPEDIC EXAM:

Mr. Smith is a well-developed, well-nourished male who appears his stated age. He is alert, oriented, and cooperative. He is appropriately attired.....Range of motion of the wrist reveals dorsiflexion to .....Non-organic signs are not present.....

NEUROLOGIC EXAM:

Neurologic exam shows strength to be 5/5 in all the major muscle groups. Reflexes are +2 and equal bilaterally. Sensation is ....

[*Complete orthopedic, neurologic, psychiatric exams are expected when the IME is performed by specialists in these fields.*]

DIAGNOSTIC STUDIES

Studies performed prior to this IME are summarized in Record Review above. No new studies are indicated for the purpose of this IME....

M. PAIN STATUS INVENTORIES

Optional: Include pain status inventories if you deem them appropriate for the worker's condition.

PAIN STATUS INVENTORIES

Please see the attached pain diagram.... We interpret the pain diagram to indicate....

CONCLUSIONS

Accepted conditions (as stated on the assignment letter from the claims manager):

#1: Right carpal tunnel syndrome

Diagnoses and assessment of work-relatedness:

Diagnoses:

#1: Right carpal tunnel syndrome
#2: Epicondylitis, right upper extremity, resolved

Pre-existing conditions:

None.

Sample Report #1:
Required Content of IME Reports in Washington State Workers' Compensation

O. DIAGNOSES AND WORK-RELATEDNESS (continued)

Conditions acquired after the industrial injury or exposure. The worker might mention new conditions or injuries. When this occurs, document the following facts for the medical record:

- Diagnosis or description of the new condition.
- Date the new condition occurred or became manifest.
- Mechanism of injury, if applicable.
- Effects of the new condition on the accepted condition.
- Conclusions about whether the accepted condition caused the new condition in whole or in part. Support your conclusion with medical facts.
- Statements about how these conditions interact.

March 2, 2005
John Smith, Claim # N100000
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Conditions acquired after the industrial injury or exposure:
Mild reactive depression.

Discussion and assessment of work-relatedness:
#1: Carpal tunnel syndrome, right upper extremity. Objective findings (positive and negative) supporting this diagnosis include positive NCVs on 1/3/05 and .....

As requested by the claims manager, we have attached the report called Doctor's Assessment of Work-Relatedness for Occupational Diseases. Please see this report for more detail on our assessment of work-relatedness.

#2: Epicondylitis, right upper extremity, resolved. Objective findings (positive and negative) supporting this diagnosis include:.....

P. DISCUSSION AND ASSESSMENT OF WORK-RELATEDNESS *

The claim manager may prefer that you NOT express an opinion about work-relatedness. Only address work relatedness if you are specifically asked to do so in the assignment letter. This could be, for example, because a condition has already been accepted and, for administrative reasons, a statement of your opinion may create difficulties.

If the claim manager does ask you to express an opinion on work-relatedness for one or more diagnoses, be sure to include the phrase "on a more probable than not basis," since this is the standard established by law. "On a more probable than not basis" does not imply a high degree of medical probability; rather it means greater than 50% certainty. See Page III 5 under Occupational Diseases. Also, see section on preexisting conditions on Pages V 4-6.

OCCUPATIONAL DISEASES: *

If one or more of the diagnoses is an occupational disease, the claim manager will need additional information. See Pages III 5-9 for more detail.

Prognosis: Not requested in the claims manager's assignment letter.

Q. PROGNOSIS
If applicable or if requested.

Physical Restrictions

Mr. Smith should not engage in repetitive forceful use of the hands as described on the Doctor's Estimate of Physical Capacities (see attachment). The basis for this restriction is his carpal tunnel syndrome…. This is a permanent restriction….

R. PHYSICAL RESTRICTIONS *
See Page III 10 and Appendix B 17. **Be sure to state the basis for the restrictions and whether permanent or temporary.** Attach the completed "Doctor's Estimate of Physical Capacities" as appropriate.

Review of Job Analyses

Job analysis #1 — Security Guard:
It is our opinion that Mr. Smith can perform the physical demands....except tasks which involve.... Job modifications should be considered to address ....

Job analysis #2 — Cashier:
It is our opinion that Mr. Smith is physically unable to perform the tasks as described because.....

S. REVIEW OF JOB ANALYSES *
See Pages III 10-11.

* **Elements marked by an asterisk should be included ONLY if specifically requested by the claim manager.**

Sample Report #1:
Required Content of IME Reports in Washington State Workers' Compensation

T. RECOMMENDATIONS ✪

Your recommendations may address both conditions related to the injury, as well as conditions unrelated but hindering recovery.

TREATMENT ✪

- Clearly state the goal of further treatment. Is it curative or palliative in nature?
- Clearly indicate if treatment is likely to restore function and/or reduce impairment. If the treatment might make a permanent improvement, even if the impairment rating remains the same, the injury is not yet stable and rating is premature.
- How long should it continue and what is the result expected?
- Guidelines. Opinions should, as much as possible, be consistent with department guidelines.

See Pages III 3-4.

U. REFERRAL FOR FINDINGS UNRELATED TO THE ACCEPTED CONDITION

Findings not related to the industrial injury may come to light during the examination. For example, you may note an elevated blood pressure while examining an injured ankle. Write a paragraph separate from your findings about the industrial injury. State that a finding, unrelated to the injury, was made and requires follow-up by the attending doctor. Comments on these conditions should be directed to the attending doctor. In some instances, it may be a good idea to phone the attending doctor to communicate your concerns directly.

V. IMPAIRMENT RATINGS ✪

The rating content described on Page V 2 is REQUIRED for all IMEs (and for ratings by attending doctors and consultants). Do NOT rate impairment if the worker is not at maximum medical improvement or if further treatment is likely to restore function. See Appendix B for sample reports.

March 2, 2005
John Smith, Claim # N100000
Page 5 of 5

Recommendations:

Diagnostic: No further testing is indicated.

Therapeutic: Mr. Smith may benefit from.... Such treatment would be palliative.... This treatment is not likely to restore function, but it could achieve.... A 3-month period of treatment would probably be sufficient to ....

Follow-up care: The treatment described above could probably be provided by Mr. Smith's current attending doctor, Dr. X. If Dr. X prefers not to provide this treatment, it may be appropriate to refer Mr. Smith to a neurologist or a specialist in ....

Findings unrelated to the accepted condition: Our exam revealed a skin condition over the posterolateral portion of the .... It appears to be .... We recommend that Mr. Smith follow-up with his attending doctor, Dr. X, as soon as possible....

Impairment Rating Report [See Appendix B for instructions and samples of rating reports.]

MMI: Mr. Smith has (or has not) reached maximum medical improvement....

Physical exam: Examination reveals....

Diagnostic tests: Electrodiagnostic studies show....

Rating: According to the *AMA Guides to the Evaluation of Permanent Impairment*, 5th edition,...

Rationale: The rationale for this rating is that, according to Table....

ANSWERS TO SPECIFIC QUESTIONS FROM THE CLAIM MANAGER

The information under "Conclusions" above gives complete answers to questions #1, 2, 3, 5, 6, 7 and 8 in the referral letter from L&I. Answers to remaining questions are given below:

Question #4: How does your physical assessment differ or concur with prior medical information regarding the patient's physical limitations? Please explain.

Answer: The physical assessment appears to concur with prior medical information.

Signed: _____ _____

Tim Jones, MD
Hand Surgery
Today's date: _____

Susan Barnes, MD
Neurology
Today's date: _____

W. ANSWERS TO CLAIM MANAGER'S QUESTIONS

If you cannot answer a question, please explain requirements for addressing it.

X. ISSUES NOT TO ADDRESS

In your recommendations and throughout your report avoid statements about the claim status such as, "The worker's claim should remain open," or "The worker's claim should be closed." Also avoid speculation about services that may be covered by industrial insurance, like, "The employer should retrain this worker." For more about this, see Page III 4.

✪ **Elements marked by an asterisk should be included ONLY if specifically requested by the claim manager.**

APPENDIX **B**

Sample Report #2: Required IME Content – Rating Only

(For brevity, the sample report below presents only key elements, omitting many details that would be expected in an actual report. Please see WAC 296-23-377 and section V of this handbook for report requirements.)

Identifying Information

Name:	John Smith	Claim #:	Y100000
Address:	2424 Poplar Drive	Date of injury:	July 7, 2002
	Seattle, WA 98100	Date of birth:	June 2, 1953

Employer at time of injury:	ABC Lumber, Inc.
Date of examination:	March 2, 2003
Location of examination:	Seattle Clinic
Examiners:	Tim Jones, MD, Orthopedic Surgery, Hand Surgery

Introduction

The opinions expressed in this report are those of the examiner. Mr. Smith was informed that this examination was at the request of the Washington State Department of Labor and Industries (L&I) and a written report would be sent to L&I and to his attending doctor, Dr. X. Mr. Smith was also informed that the examination was for evaluative purposes only, intended to address specific injuries or conditions as outlined by L&I, rather than to constitute a general medical examination.

Mr. Smith was asked at the time of the examination not to engage in any physical maneuvers beyond what he could tolerate, or which he felt were beyond his limits, or which could cause harm or injury.

The historical portion of this report is being dictated in the presence of the claimant so that additions or corrections can be made if necessary. His friend, Sally Rogers, accompanied Mr. Smith to the exam.

History From the Worker

Chief complaints (current symptoms):

1) Decreased strength in the right hand, dominant extremity
2) Tingling in the right hand and palm with intermittent tingling and numbness in the left hand.

History of present injury:

Mr. Smith is a 49-year-old greenchain puller at ABC Lumber. He has held this job for 13 years. He...

Record Review

The chart has been reviewed in detail. Records reviewed and pertinent data from those records include the following:

- Chart notes of Brian Johnson, M.D., Family Practice, from 3/2/02 through 1/3/03. 7/7/02: Dr. Johnson saw Mr. Smith for complains about his right hand....1/3/03: Mr. Smith reported substantial improvement in his symptoms with conservative care....
- Chart notes of Mary Miller, D.O., Neurologist, from 9/5/02 through 11/4/02. 9/5/02: Dr. Miller saw Mr. Smith for the first time. She reported a normal neurologic exam....
- Electrodiagnostic report of William Jones, M.D., Neurologist, performed on 10/3/02. EMG revealed.....

Physical examination

Neurologic exam shows strength to be 5/5 in all the major muscle groups, except in the hand, as described below. Reflexes are...

[Complete physical examination is expected as appropriate for the issues involved in the case.]

Diagnosis

#1: Carpal tunnel syndrome, right upper extremity

#2: Epicondylitis, right upper extremity, resolved

Impairment Rating

1. MMI: I concur with the January 3, 2003 report from Dr. Johnson, the attending physician, that Mr. Smith has reached maximum medical improvement.

2. Physical exam: Positive and negative examination finding relevant to the impairment rating include the following: atrophy of the thenar muscles; presence of Phalen's sign; moderate weakness of thumb abduction: ....

3. Diagnostic tests: On October 3, 2002 electrodiagnostic studies revealed... No new studies are indicated for the purpose of this IME ...

4. Rating: According to the American Medical Association *Gudes to the Evaluation of Permanent Impairment*, 5th Edition, it is my opinion that the findings correspond most closely to a rating of ...

5. Rationale: The rationale for this rating is that, using Section 16.5d on pages 491 through 495 of the 5th edition of the AMA *Guides to the Evaluation of Permanent Impairment* ...

Signed: _____

Tim Jones, MD
Orthopedic Surgery, Hand Surgery

SAMPLE RATING REPORT #3

Required Content of an Attending Doctor Rating Report

This sample report illustrates the five required components of an Attending Doctor rating report. (Please see Page V 2 for details.)

For a patient with this clinical data … :

Mr. A., a 28-year-old male, was injured lifting a 50-pound container out of a van. He developed sharp low back pain radiating down the left lower extremity into the foot. The patient received non-operative treatment, including physical therapy and non-steroidal medications. At the time of the impairment rating examination, Mr. A. reported moderate intermittent pain. Physical examination was remarkable for decreased sensation to pinprick over the lateral left leg and foot; positive SLR on the left at 30 degrees with increased radicular pain on ankle dorsiflexion; and tenderness at L5-S1 with deep pressure. X-rays showed 25% loss of disc height at L5-S1 disc.

The Rating Report should read as follows:

MMI: Mr. A. has reached maximum medical improvement. No further curative treatment is recommended.

Physical exam: Examination does not reveal any muscle weakness, atrophy, or reflex loss. There is decreased sensation to pinprick over the lateral left leg and foot; positive SLR at 30 degrees with increased radicular pain on ankle dorsiflexion; and tenderness at L5-S1 with deep pressure.

Diagnostic tests: X-rays show 25% loss of disc height at L5-S1 disc.

Rating: According to the Washington State Category Rating System, it is my opinion that these findings correspond most closely to an impairment rating of Category 2.

Rationale: The rationale for this rating is that I consider the 25% loss of disc height at the L5-S1 disc to be "mild but significant." I consider his findings of decreased sensation in a dermatomal distribution and positive SLR to be "moderate intermittent." He has no atrophy, muscle weakness, reflex loss or other significant findings.

SAMPLE RATING REPORT #4

Previously asymptomatic worker, with preexisting x-ray findings ("lighting up" & the Miller decision)

This sample report illustrates the "lighting up" principle described in the Miller decision. (Please see Pages V 4-5 for details about dealing with preexisting conditions, segregation, and "lighting up.")

As illustrated in this sample rating report, in cases of "lighting up" the doctor should NOT segregate preexisting impairment or express any opinion about the significance of preexisting findings. (Please compare this with sample rating report #5.)

For a patient with this clinical data … :

Mr. B. is a 50-year-old truck driver with no history of back symptoms or disabling back condition. He sustains an injury lifting a 50-pound crate. After conservative treatment, he reaches a plateau at which he continues to experience moderate, intermittent radicular pain. Physical examination was remarkable for decreased sensation to pinprick over the lateral left leg and foot; positive SLR on the left at 30 degrees with increased radicular pain on ankle dorsiflexion; tenderness at L5-S1 with deep pressure. X-rays reveal mild-to-moderate degenerative changes at L5-S1.

The report could read something like this:

MMI: Mr. B. has reached maximum medical improvement. No further curative treatment is recommended.

Physical exam: Examination does not reveal any muscle weakness, atrophy, or reflex loss. Examination was remarkable for decreased sensation to pinprick over the lateral left leg and foot; positive SLR on the left at 30 degrees with increased radicular pain on ankle dorsiflexion; tenderness at L5-S1 with deep pressure.

Diagnostic tests: On x-ray he has degenerative changes at L5-S1.

Rating: According to the Washington State Category Rating System, it is my opinion that these findings indicate an impairment of Category 2.

Rationale: The rationale for this rating is that I consider the degenerative changes at L5-S1 to be "mild but significant," and consistent with the pain Mr. B describes. I consider his findings of decreased sensation in a dermatomal distribution and positive SLR to be "moderate intermittent." He lacks other significant findings.

SAMPLE RATING REPORT # 5

Patient with symptomatic preexisting condition, whose medical records include data on which to base a rating of preexisting impairment, and the claim manager explicitly asked the examiner to segregate

This sample report illustrates a patient with a symptomatic preexisting condition, where the "lighting up" principle described in the Miller decision does NOT apply. (Please see Pages V 4-5 for details about dealing with preexisting conditions, segregation, and "lighting up.")

As illustrated in this sample rating report, in cases where the "lighting up" principle does not apply, the doctor should rate the impairment that existed prior to the worker's injury, and provide documentation as described on Pages V 4-5. (Please compare this with sample rating report #4.)

Report:

MMI: Mr. C. has reached maximum medical improvement. No further curative treatment is recommended.

Physical exam: Examination reveals 2 cm. of calf atrophy on the right and diminished Achilles reflex on the right. There is mild muscle weakness and mild decrease in sensation to pinprick over the lateral right leg and foot. There are no other significant findings.

Diagnostic tests: He has x-ray changes from his fusion at L5-S1.

Rating: According to the Washington State Category Rating System, it is my opinion that the most appropriate impairment rating for Mr. C.'s current condition is Category 5.

Rationale: The rationale for this rating is that Mr. E. has pseudoarthrosis of the lumbar fusion with 30% loss of disc height at L5-S1, which I would categorize as marked. He has 2 cm. of calf atrophy on the right and diminished Achilles reflex on the right. There is mild muscle weakness and mild decrease in sensation to pinprick over the lateral right leg and foot. There were no other significant findings.

Preexisting conditions: Mr. C. had a previous non-industrial back injury on July 15, 1988. I have been seeing him periodically for this injury since January, 1991. I examined Mr. C. three months prior to the industrial injury. At that time, examination did not reveal any muscle weakness, atrophy, reflex loss, sensory loss, or other significant findings. He did have a bulging disc at L5-S1, which I considered insignificant. According to the Washington State Category Rating System, it is my opinion that these findings indicate a preexisting impairment rating of Category 1.

SAMPLE REPORT #6

Required Content of the Doctor's Assessment of Work Relatedness for Occupational Diseases.

On the following six pages are the Doctor's Assessment of Work Relatedness for Occupational Diseases and a blank copy of the Occupational Disease Work History form. The form is filled out and signed by the worker at the request of the claim manager. The information is used to determine which jobs, if any, contributed to the alleged occupational disease.

What do you need to do?

The Occupational Disease Work History form, already completed by the worker, should be provided to you by the claim manager prior to the IME with the rest of the medical records.

Review the completed work history form with the worker to gather additional detail about each job's activities. Use the detail to support your conclusions.

Sample Report #6:
Required Content of Occupational Disease Reports in Washington State Workers' Compensation

Department of LABOR AND INDUSTRIES

Please use this Sample Report as a "template" when you dictate your reports so you remember to include all the information required.

DOCTOR'S ASSESSMENT OF WORK-RELATEDNESS FOR OCCUPATIONAL DISEASES

A. IDENTIFYING INFORMATION

Name:	Mary Johnson	**Claim #:**	P200000
Address:	9898 Tulip Street, Anywhere, WA 98100	**Date of Injury:**	December 1, 1992
		Date of Birth:	April 1, 1958

Employer at Time of the Claim: Chicken Industries, Inc.

Date of Examination: June 12, 2002

Location of Examination: XYZ Clinic, Seattle, WA

Examiners: Joanne Taylor, M.D., Neurology

B. SOURCE OF INFORMATION FOR THIS REPORT

When IME examiners are requested to submit this report, the claim manager should provide you with a copy of the "Occupational Disease Work History Form" already filled out by the worker. Attending doctors and consultants may request it from the claim manager. **The doctor must review the form with the worker to gather information necessary to provide the occupational history described below.**

See i). below

B. SOURCE OF INFORMATION FOR THIS REPORT

The Occupational Disease Work History Form was provided to us by the claims manager prior to the examination. It had been completed by Ms. Johnson at home. I have discussed the information on the form with Ms. Johnson and gathered additional details, which form the basis for the opinions presented below. In addition, a job analysis for job #1 was provided by the claims manager and is discussed in the next section. Also, an industrial hygiene report was available for job #2 and is described below. No documentation was available for jobs #3 through #10, so opinions are based solely on the patient's history.

For the record, I am attaching a copy of the Occupational Disease Work History Form which Ms. Johnson filled out. I have numbered the jobs for easy reference in this report. Numbers start with #1 (Poultry worker at Chicken Industries, Inc. from 1994-2000) and go in reverse chronological order through #10 (Cashier at ABC Food Stop from 1979-1980).

C. ANSWERS TO THE FOUR REQUIRED QUESTIONS ABOUT WORK ACTIVITIES

For legal reasons, you MUST re-state each of the four questions in your report, EXACTLY as written below.

C. ANSWERS TO THE FOUR REQUIRED QUESTIONS ABOUT WORK ACTIVITIES

Question #1: **Have you discussed with the claimant the work activities of ALL jobs listed in the work history (including discussion of protective equipment and engineering controls)?**
Yes.

C.1 The answer to this question should almost always be "yes."

Question #2: **What conditions have you diagnosed?**
Diagnosis #1: Carpal tunnel syndrome, right upper extremity

C.2 Briefly (in one line or so) state your diagnosis or diagnoses. Number each diagnosis for later reference.

i). If the claim manager has not provided the Occupational Disease Work History form to you, you may request it from the claim manager, or you may ask the worker to complete the form (or a form of equivalent content). The form may be photocopied from Pages B 15-16, or copies may be obtained free of charge by mailing a request to the address in item #11 inside the back cover of this handbook. Ask for forms #F242-071-000 (first sheet) and #F242-071-111 (continuation sheet) or download at www.LNI.wa.gov/formpublications/formsbyname.asp .

As much as possible, the claim manager will provide industrial hygiene reports, Material Safety Data Sheets, job analyses, or any other material that may be helpful to you for your assessment of work-relatedness.

Sample Report #6:
Required Content of Occupational Disease Reports in Washington State Workers' Compensation

C.3 Certain jobs are known to create a recognizable risk of contracting work-related conditions relative to everyday life.

See ii). below.

C.4a This information is needed to establish the legal requirement of proximate cause. Please reference industrial hygiene reports, information from the employer and/or coworkers, Material Safety Data Sheets (MSDSs), or any other documentation that supports your opinion that the activity/exposure occurred.

C.4a Personal protective equipment is used or worn by the worker to reduce personal exposures and include such things as ear plugs, gloves, hard hats, safety glasses and respirators. Engineering controls are designed as part of the work process or environment to reduce personal and/or general area exposures, examples of which include ventilation hoods, machine guards or enclosures, mechanical lifts and vibration or sound-absorbing materials and mats.

As always, put the claim number in the top right corner of every page.

Question #3: **For each condition in Question #2 which is considered a disease (rather than an injury), which jobs in the work history created a recognizable risk of contracting (or worsening) this work-related condition *relative to the risks in everyday life*, on a more-probable-than-not basis? Which jobs did NOT create such a risk?**

Diagnosis # 1: Carpal Tunnel Syndrome, Right Upper Extremity

On a more-probable-than-not basis, jobs #1 and #2 created a recognizable risk of contracting this condition, relative to the risks in everyday life.

Jobs #3-10 did not create such a risk, on a more-probable-than-not basis.

Question #4: **For each job that did create a recognizable risk, answer BOTH of the following questions:**

a) **Describe the job. Be sure to include the work activities and/or exposures which contributed to (or protected the worker from) the disease (proximate causes). Describe any protective equipment or engineering controls (or lack thereof) that may have affected the exposure.**

b) **Describe the basis for your opinion that the workplace activities contributed to the disease. Please include:**

- **A description of the temporal relationship. In your description of the temporal relationship, be sure to mention, for each job, when the worker began to experience symptoms and how the onset and pattern of symptoms related to work activities.**
- **Any other information you deem relevant (such as supporting references from the medical literature).**

Be sure to include information requested in part a) of this question (see C.4a above).

JOB #1

Job title:	Poultry worker
Employer:	Chicken Industries, Inc.
Employer's city and state:	Tacoma, WA
Approximate dates of employment:	September 1994-December 2000

a) **Job description:** Ms. Johnson reports that her job includes cutting up chicken parts with a hand-held knife to remove bones from the meat. The job involves a significant amount of repetition and force. Ms. Johnson estimates that she spends at least 6.5 hours a day at this task. The work rate is 90 chickens an hour. The claims manager provided a job analysis from the employer which confirms the nature and duration of the task and adds that they are in the process of trying to reduce the "repetitiveness" of the task by incorporating job rotation into their work practices policy.

ii). Examples include:
- Health care workers and the development of latex sensitivity.
- Meat packers or poultry plant workers and the development of carpal tunnel syndrome.
- Bakers and the development of asthma.

Other jobs may not have such a well-established association, but may nevertheless contribute, on a more-probable-than-not basis. In all cases, your answer to Question #4 should adequately support your answer to Question #3.

Sample Report #6:
Required Content of Occupational Disease Reports in Washington State Workers' Compensation

C.4b Describe the basis for your opinion that the workplace activities contributed to the disease. **Be sure to include information requested in part (b) of this question.**

See previous page and See iii). below

b) Basis for my opinions: The repetitive, forceful work of cutting up chicken parts is likely to have contributed to Ms. Johnson's carpal tunnel syndrome. It is well documented in the medical literature that repetitive tasks which require force are associated with the development of carpal tunnel syndrome. This disorder is common among workers from other industries and occupations that are also associated with repetitive, forceful work. Furthermore, there is a clear temporal relationship between the onset and pattern of her symptoms and her work activities. Her symptoms began approximately six months after... In August 1992 Ms. Johnson took a week-long vacation during which her symptoms...

Repeat the steps above for each job that created a recognizable risk.

JOB #2

Job title:	Laborer
Employer:	ABC Wallboard International
Employer's city and state:	Tacoma, WA
Approximate dates of employment:	April 1991-June 1991

a) Job description: This job involved the installation of wallboard in both residential and non-residential buildings. Ms. Johnson described the job to be very demanding. The tasks associated with installing wallboard include repetitive and forceful motions, specifically with the use of a pneumatic nail gun, which was so heavy it required the use of both arms to operate. The nature of the work often required that the nail gun be used in awkward postures. The employer's description of the job was consistent with that of Ms. Johnson. An industrial hygiene report was also available. It documented....

b) Basis for my opinions: The repetitive, forceful work of installing wallboard is likely to have contributed to Ms. Johnson's carpal tunnel syndrome. I have observed this condition in laborers before. Just as in Job #1, it is well documented in the medical literature that repetitive tasks which require force are associated with the development carpal tunnel syndrome. The types of motions known to be associated with carpal tunnel syndrome were demonstrated by Ms. Johnson in her description of operating the nail gun as well as in other tasks necessary to perform her job such as handling the wallboard. Also, there is a clear temporal relationship between the onset and pattern of her symptoms and her work activities. Although her symptoms in this job were not as severe as in Job #1, ...

iii). In many cases only limited information on the work exposures will be available. The claim manager understands that it may be difficult to assess work-relatedness without complete information. Therefore, the expectation is that you will make as accurate a determination as possible, based on whatever information is available at the time of the examination.

Sample Report #6:
Required Content of Occupational Disease Reports in Washington State Workers' Compensation

D. ANSWERS TO THE TWO REQUIRED QUESTIONS ABOUT NON-WORK ACTIVITIES

For legal reasons, you MUST re-state each of the two questions in your report, exactly as written below.

D.5 Does the worker report any non-work activities or exposures that may have an effect on the diagnosed condition? An example is a receptionist who has bilateral carpal tunnel syndrome which may be a result of crocheting projects done on non-work time.

D.6 Give a clear statement of the association (or lack of association) between the exposure and the condition, on a more-probable-than-not basis. Please include, for example, a description of the temporal relationship, supporting references from the medical literature, and any other information you deem relevant.

D. ANSWERS TO THE TWO REQUIRED QUESTIONS ABOUT NON-WORK ACTIVITIES

Question #5: **Describe non-work activities or conditions that may have an effect on the disease.**

Ms. Johnson's hobbies include body work on her car and the cars of friends and relatives. She reports doing body work roughly 2 hours per week over the last two years....

Question #6: **If you believe the disease was caused SOLELY by non-work activities or conditions, describe the basis for your opinion. Please include, for example, a description of the temporal relationship, supporting references from the medical literature, and any other information you deem relevant.**

Not applicable.

D.6 You should not answer this question if you indicated in Question #3 that any of the jobs the worker has performed created a recognizable risk of contracting the condition relative to the risks in everyday life.

Signed: _____
Joanne Taylor, M.D., Attending Doctor
Neurology
Today's Date: _____

APPENDIX B

Department of Labor and Industries
Claims Section
PO Box 44291
Olympia WA 98504-4291

OCCUPATIONAL DISEASE WORK HISTORY

Claim Number

Name	Start date of first employment

Please list any breaks or interruption in your work history. ***We must account for all months since your FIRST START DATE*.**

From:		To:		Reason for work interruption
Month	Year	Month	Year	

Employment History

Please start with your most RECENT job and work BACKWARDS Specify month and year for employment date.

If additional space is needed, use the continuation form (F242-071-111) or make additional copies of this form.

Employer's business name	Employment dates: From (mo/yr)	To (mo/yr)
Employer's address	Employer's phone number	
City State ZIP+4	Indicate time exposed to noise, repetitive motion or chemicals in hours per week Hours:	

Describe the job duties and type of equipment or tools used or operated.

Employer's business name	Employment dates: From (mo/yr)	To (mo/yr)
Employer's address	Employer's phone number	
City State ZIP+4	Indicate time exposed to noise, repetitive motion or chemicals in hours per week Hours:	

Describe the job duties and type of equipment or tools used or operated.

Employer's business name	Employment dates: From (mo/yr)	To (mo/yr)
Employer's address	Employer's phone number	
City State ZIP+4	Indicate time exposed to noise, repetitive motion or chemicals in hours per week Hours:	

Describe the job duties and type of equipment or tools used or operated.

I certify that the information is true and correct to the best of my knowledge.

Page of

Date: Signature:

APPENDIX B

F242-071-000 occupational disease work history 5-00

OCCUPATIONAL DISEASE WORK HISTORY (CONTINUATION)

Page of	Name	Claim Number

(This is a continuation sheet. Must complete original form first.)

Please CONTINUE with your most RECENT job and work BACKWARDS.

Employer's business name	Employment dates: From (mo/yr)	To (mo/yr)
Employer's address	Employer's phone number	
City State ZIP+4	Indicate time exposed to noise, repetitive motion or chemicals in hours per week Hours:	

Describe the job duties and type of equipment or tools used or operated.

Employer's business name	Employment dates: From (mo/yr)	To (mo/yr)
Employer's address	Employer's phone number	
City State ZIP+4	Indicate time exposed to noise, repetitive motion or chemicals in hours per week Hours:	

Describe the job duties and type of equipment or tools used or operated.

Employer's business name	Employment dates: From (mo/yr)	To (mo/yr)
Employer's address	Employer's phone number	
City State ZIP+4	Indicate time exposed to noise, repetitive motion or chemicals in hours per week Hours:	

Describe the job duties and type of equipment or tools used or operated.

Employer's business name	Employment dates: From (mo/yr)	To (mo/yr)
Employer's address	Employer's phone number	
City State ZIP+4	Indicate time exposed to noise, repetitive motion or chemicals in hours per week Hours:	

Describe the job duties and type of equipment or tools used or operated.

Employer's business name	Employment dates: From (mo/yr)	To (mo/yr)
Employer's address	Employer's phone number	
City State ZIP+4	Indicate time exposed to noise, repetitive motion or chemicals in hours per week Hours:	

Describe the job duties and type of equipment or tools used or operated.

Dept of Labor & Industries
PO Box 44291
Olympia WA 98504-4291

I certify that the information is true and correct to the best of my knowledge.

Date: Signature:

F242-071-111 occupational disease work history (continuation) 5-00

APPENDIX **B**

Department of Labor and Industries
Claims Section
PO Box 44291
Olympia WA 98504-4291

DOCTOR'S ESTIMATE OF PHYSICAL CAPACITIES

Name of Claimant

Claim Number

Important: Please complete the following items based on your clinical evaluation of the claimant and other testing results. Any item that you do not believe you can answer should be marked N/A. Percentages refer to a workday.

I. In an 8 hour workday, worker can: (Circle full capacity for each activity)

	Total at one time (hours)										Total during entire 8 hour day (hours)									
A)	Sit	0	1/2	1	2	3	4	5	6	7	8	A) Sit	0	1/2	1	2	3	4	5	6	7	8
B)	Stand	0	1/2	1	2	3	4	5	6	7	8	B) Stand	0	1/2	1	2	3	4	5	6	7	8
C)	Walk	0	1/2	1	2	3	4	5	6	7	8	C) Walk	0	1/2	1	2	3	4	5	6	7	8

II. Worker can lift: *(Address any restrictions in lifting from the floor or to overhead in "Remarks" section)*

III. Worker can carry:

		Never		Seldom (0 - 1%)		Occasionally (2 - 33%)		Frequently (34 - 66%)		Continuously (67 - 100%)	
		Lift	**Carry**	**Lift**	**Carry**	**Lift**	**Carry**	**Lift**	**Carry**	**Lift**	**Carry**
A)	Up to 5 lbs										
B)	6 - 10 lbs										
C)	11 - 20 lbs										
D)	21 - 25 lbs										
E)	26 - 50 lbs										
F)	51 - 100 lbs										

IV. Worker can use hands for repetitive tasks such as:

		Simple grasping		Pushing & pulling		Fine manipulating	
A)	Right	Yes	No	Yes	No	Yes	No
B)	Left	Yes	No	Yes	No	Yes	No

V. Worker can use feet for repetitive movements as in operating foot controls:

Right Yes No Left Yes No

VI. Worker is able to:

		Not at all	Seldom (0 - 1%)	Occasionally (2 - 33%)	Frequently (34 - 66%)	Continuously (67 - 100%)
A)	Bend					
B)	Squat					
C)	Kneel					
D)	Crawl					
E)	Climb					
F)	Reach above shoulder level					

VII. Restriction on activities involving:

		Yes	No	If "Yes," explain:
A)	Unprotected heights			
B)	Being around moving machinery			
C)	Exposure to marked changes in temp & humidity			
D)	Driving automotive equipment			

E) Exposure to dust, fumes and gasses (Restrictions): _____

Remarks (on above, on other functional limitations):

If a performance-based physical capabilities evaluation is requested, may the worker be tested to tolerance? If not, what are the restrictions?

Yes No

F242-022-000 Dr's est of physical capacities 8-98

Date Signature of Physician

APPENDIX B

How are physical demands defined?

U.S. Department of Labor classification of physical demands and environmental conditions

Physical demands analysis is a systematic way of describing the physical activities that a job requires. It is concerned only with the physical demands of the job; it is not concerned with the physical capacity of the worker. Environmental conditions are the surroundings in which a job is performed. To be considered present, an environmental condition must be specific and related to the job.

The above information was taken from *The Revised Handbook for Analyzing Jobs, U.S. Department of Labor, 1991, Pages 12-1 to 12-13.)*

Physical Demands

1. ***Strength***

   This factor is expressed by one of five terms: sedentary, light, medium, heavy and very heavy. In order to determine the overall rating, an evaluation is made of the worker's involvement in the following activities:

   Position

   Standing: Remaining on one's feet in an upright position at a workstation without moving about.

   Walking: Moving about on foot.

   Sitting: Remaining in a seated position.

   Weight/Force

   Lifting: Raising or lowering an object from one level to another (includes upward pulling).

   Carrying: Transporting an object, usually holding it in the hands or arms or on the shoulder.

   Pushing: Exerting force upon an object so that the object moves away from the force (includes slapping, striking, kicking and treadle actions).

   Pulling: Exerting force upon an object so that the object moves toward the force (includes jerking).

   Lifting, pushing and pulling are expressed in terms of both intensity and duration. Judgments regarding intensity involve consideration of the weight handled, position of the worker's body or the part of the worker's body used in handling weights, and the aid given by helpers or by mechanical equipment. Duration is the total time spent by the worker in carrying out these activities. Carrying most often is expressed in terms of duration, weight carried and distance carried.

   Controls: Hand-Arm and Foot-Leg Controls entail use of one or both arms or hands (hand-arm) or one or both feet or legs (foot-leg) to move controls on machinery or equipment. Controls include but are not limited to buttons, pedals, levers and cranks.

   Sedentary Work
   Exerting up to 10 pounds of force occasionally or a negligible amount of force frequently to lift, carry, push, pull or otherwise move objects, including the human body. Sedentary work involves sitting most of the time, but may involve walking or standing brief periods of time. Jobs are sedentary if walking and standing are required only occasionally and all other sedentary criteria are met.

   Light Work
   Exerting up to 20 pounds of force occasionally, or up to 10 pounds of force frequently, or a negligible amount of force constantly to move objects. Physical demand requirements are in excess of those for sedentary work. Even though the weight lifted may be only a negligible amount, a job should be rated light work: (1) when it requires walking and standing to a significant degree; (2) when it requires sitting most of the time but entails pushing and pulling of arm or leg controls; or (3) when the job requires working a production rate pace entailing the constant pushing or pulling of materials even though the weight of those materials is negligible. NOTE: The constant stress and strain of maintaining a production rate pace, especially in an industrial setting, can be and is physically demanding of a worker even though the amount of force exerted is negligible.

   Medium Work
   Exerting 20 to 50 pounds of force occasionally, or 10 to 25 pounds of force frequently, or greater than negligible up to 10 pounds of force constantly to move objects.

   Heavy Work
   Exerting 50 to 100 pounds of force occasionally, or 25 to 50 pounds of force frequently, or 10 to 20 pounds of force constantly to move objects.

   Very Heavy
   Exerting in excess of 100 pounds of force occasionally, or in excess of 50 pounds of force frequently, or in excess of 20 pounds of force constantly to move objects.

2. ***Climbing***
   Ascending or descending ladders, stairs, scaffolding, ramps, poles and the like, using feet and legs or hands and arms. Body agility is emphasized.

3. ***Balancing***
   Maintaining body equilibrium to prevent falling when walking, standing, crouching, or running on narrow, slippery, or erratically moving surfaces; or maintaining body equilibrium when performing gymnastic feats.
4. ***Stooping***
   Bending the body downward and forward by bending the spine at the waist, requiring full use of the lower extremities and back muscles.
5. ***Kneeling***
   Bending the legs at the knees at come to rest on the knees or knees.
6. ***Crouching***
   Bending the body downward and forward by bending the legs and spine.
7. ***Crawling***
   Moving about on the hands and knees or hands and feet.
8. ***Reaching***
   Extending, the hand(s) and arm(s) in any direction.
9. ***Handling***
   Seizing, holding, grasping, turning or otherwise working with the hand or hands. Fingers are involved only to the extent that they are an extension of the hand, such as to turn a switch or shift automobile gears.
10. ***Fingering***
    Picking, pinching or otherwise working primarily with the fingers rather than with the whole hand or arm as in handling.
11. ***Feeling***
    Perceiving attributes of objects, such as size, shape, temperature or texture, by touching with skin, particularly that of fingertips.
12. ***Talking***
    Expressing or exchanging ideas by means of the spoken word to impart oral information to clients or to the public and to convey detailed spoken instructions to other workers accurately, loudly, or quickly.
13. ***Hearing***
    Perceiving nature of sounds by ear.
14. ***Tasting/Smelling***
    Distinguishing, with a degree of accuracy, differences or similarities in intensity or quality of flavors or odors, or recognizing particular flavors or odors, using tongue or nose.
15. ***Near Acuity***
    Clarity of vision at 20 inches or less.
16. ***Far Acuity***
    Clarity of vision at 20 feet or more.
17. ***Depth Perception***
    Three-dimensional vision. Ability to judge distances and spatial relationships in order to see objects where and as they actually are.
18. ***Accommodation***
    Adjustment of lens of eye to bring an object into sharp focus. This factor is required when doing near point work at varying distance from the eye.
19. ***Color Vision***
    Ability to identify and distinguish colors.
20. ***Field of Vision***
    Observing an area that can be seen up and down or to right or left while eyes are fixed on a given point.

Environmental Condition Factors

1. ***Exposure to Weather***
   Exposure to outside atmospheric conditions.
2. ***Extreme Cold***
   Exposure to non-weather-related cold temperatures.
3. ***Extreme Heat***
   Exposure to non-weather-related hot temperatures.
4. ***Wet and/or Humid***
   Contact with water or other liquids or exposure to non-weather-related humid conditions.
5. ***Noise Intensity Level***
   The noise intensity level to which the worker is exposed in the job environment. This factor is expressed by one of five levels. Consider all the benchmarks within a level as providing an insight into the nature of the specific level.
6. ***Vibrations***
   Exposure to a shaking object or surface.
7. ***Atmospheric Conditions***
   Exposure to conditions such as fumes, noxious odors, dusts, mists, gases and poor ventilation, that affect the respiratory system, eyes or skin.
8. ***Proximity to Moving Mechanical Parts***
   Exposure to possible bodily injury from moving mechanical parts of equipment, tools or machinery.
9. ***Exposure to Electrical Shock***
   Exposure to possible bodily injury from electrical shock.
10. ***Working in High, Exposed Places***
    Exposure to bodily injury from falling.
11. ***Exposure to Radiation***
    Exposure to possible bodily injury from radiation.
12. ***Working with Explosives***
    Exposure to possible injury from explosions.
13. ***Exposure to Toxic or Caustic Chemicals.***
    Exposure to possible bodily injury from toxic or caustic chemicals.
14. ***Other Environmental Conditions***
    Explain other environmental conditions, not defined above, in Environmental Conditions Comments.

Appendix C
Relevant Laws and Regulations

Washington state laws (Revised Code of Washington – RCW) and regulations (Washington Administrative Code – WAC) relevant to independent medical exams are listed in this appendix.

Regulations (WACs) relevant to specific impairment ratings of body systems can be found on Pages V 7-42.

Laws

RCW 51.04.050
Physician or licensed advanced registered nurse practitioner's testimony not privileged

In all hearings, actions or proceedings before the department or the board of industrial insurance appeals, or before any court on appeal from the board, any physician or licensed advanced registered nurse practitioner having theretofore examined or treated the claimant may be required to testify fully regarding such examination or treatment, and shall not be exempt from so testifying by reason of the relation of physician to patient or licensed advanced registered nurse practitioner.

RCW 51.08.100
Injury

"Injury" means a sudden and tangible happening, of a traumatic nature, producing an immediate or prompt result, and occurring from without, and such physical conditions as result therefrom.

RCW 51.08.140
Occupational disease

"Occupational disease" means such disease or infection as arises naturally and proximately out of employment under the mandatory or elective adoption provisions of this title.

RCW 51.08.142
"Occupational disease"—Exclusion of mental conditions caused by stress

The department shall adopt a rule pursuant to chapter 34.05 RCW that claims based on mental conditions or mental disabilities caused by stress do not fall within the definition of occupational disease in RCW 51.08.140.

RCW 51.32.055 (4)
Determination of permanent disabilities—Closure of claims by self-insurers

The department or, in cases authorized in subsection (9) of this section, the self-insurer, may require that the worker present himself or herself for a special medical examination by a physician or physicians selected by the department, and the department or, in cases authorized in subsection (9) of this section, the self-insurer may require that the worker present himself or herself for a personal interview. The costs of the examination or interview, including payment of any reasonable travel expenses, shall be paid by the department or self-insurer, as the case may be.

RCW 51.32.080
Permanent partial disability – Specified – Unspecified, rules for classification – Injury after permanent partial disability

(1)(a) Until July 1, 1993, for the permanent partial disabilities here specifically described, the injured worker shall receive compensation as follows:

LOSS BY AMPUTATION

Of leg above the knee joint with short thigh stump (3" or less below the tuberosity of ischium)	$54,000.00
Of leg at or above knee joint with functional stump	48,600.00
Of leg below knee joint	43,200.00
Of leg at ankle (Syme)	37,800.00
Of foot at mid-metatarsals	18,900.00
Of great toe with resection of metatarsal bone	11,340.00
Of great toe at metatarsophalangeal joint	6,804.00
Of great toe at interphalangeal joint	3,600.00
Of lesser toes (2nd to 5th) with resection of metatarsal bone	4,140.00
Of lesser toe at metatarsophalangeal joint	2,016.00
Of lesser toe at proximal interphalangeal joint	1,494.00
Of lesser toe at distal interphalangeal joint	378.00
Of arm at or above the deltoid insertion or by disarticulation at the shoulder	54,000.00
Of arm at any point from below the deltoid insertion to below the elbow joint at the insertion of the biceps tendon	51,300.00
Of arm at any point from below the elbow joint distal to the insertion of the biceps tendon to and including mid-metacarpal amputation of the hand	48,600.00
Of all fingers except the thumb at metacarpophalangeal joints	29,160.00
Of thumb at metacarpophalangeal joint or with resection of carpometacarpal bone	19,440.00
Of thumb at interphalangeal joint	9,720.00
Of index finger at metacarpophalangeal joint or with resection of metacarpal bone	12,150.00
Of index finger at proximal interphalangeal joint	9,720.00
Of index finger at distal interphalangeal joint	5,346.00
Of middle finger at metacarpophalangeal joint or with resection of metacarpal bone	9,720.00
Of middle finger at proximal interphalangeal joint	7,776.00
Of middle finger at distal interphalangeal joint	4,374.00
Of ring finger at metacarpophalangeal joint or with resection of metacarpal bone	4,860.00
Of ring finger at proximal interphalangeal joint	3,888.00
Of ring finger at distal interphalangeal joint	2,430.00
Of little finger at metacarpophalangeal joint or with resection of metacarpal bone	2,430.00
Of little finger at proximal interphalangeal joint	1,944.00
Of little finger at distal interphalangeal joint	972.00

Miscellaneous	
Loss of one eye by enucleation	21,600.00
Loss of central visual acuity in one eye	18,000.00
Complete loss of hearing in both ears	43,200.00
Complete loss of hearing in one ear	7,200.00

(b) Beginning on July 1, 1993, compensation under this subsection shall be computed as follows:

(i) Beginning on July 1, 1993, the compensation amounts for the specified disabilities listed in (a) of this subsection shall be increased by thirty-two percent; and

(ii) Beginning on July 1, 1994, and each July 1 thereafter, the compensation amounts for the specified disabilities listed in (a) of this subsection, as adjusted under (b) (i) of this subsection, shall be readjusted to reflect the percentage change in this consumer price index calculated as follows: The index for the calendar year preceding the year in which the July calculation is made, to be known as "calendar year A," is divided by the index for the calendar year preceding calendar year A, and the resulting ratio is multiplied by the compensation amount in effect on June 30 immediately preceding the July 1st on which the respective calculation is made. For the purposes of this subsection, "index" means the same as the definition in RCW 2.12.037(1).

(2) Compensation for amputation of a member or part thereof at a site other than those specified in subsection (1) of this section, and for loss of central visual acuity and loss of hearing other than complete, shall be in proportion to that which such other amputation or partial loss of visual acuity or hearing most closely resembles and approximates. Compensation shall be calculated based on the adjusted schedule of compensation in effect for the respective time period as prescribed in subsection (1) of this section.

(3) (a) Compensation for any other permanent partial disability not involving amputation shall be in the proportion which the extent of such other disability, called unspecified disability, shall bear to the disabilities specified in subsection (1) of this section, which most closely resembles and approximates in degree of disability such other disability, and compensation for any other unspecified permanent partial disability shall be in an amount as measured and compared to total bodily impairment. To reduce litigation and establish more certainty and uniformity in the rating of unspecified permanent partial disabilities, the department shall enact rules having the force of law classifying such disabilities in the proportion which the department shall determine such disabilities reasonably bear to total bodily impairment. In enacting such rules, the department shall give consideration to, but need not necessarily adopt, any nationally recognized medical standards or guides for determining various bodily impairments.

(b) Until July 1, 1993, for purposes of calculating monetary benefits under (a) of this subsection, the amount payable for total bodily impairment shall be deemed to be ninety thousand dollars. Beginning on July 1, 1993, for the purposes of calculating monetary benefits under (a) of this subsection, the amount payable for total bodily impairment shall be adjusted as follows:

(i) Beginning July 1, 1993, the amount payable for total bodily impairment under this section shall be increased to one hundred eighteen thousand eight hundred dollars; and

(ii) Beginning July 1, 1994, and each July 1 thereafter, the amount payable for total bodily impairment prescribed in (b) (i) of this subsection shall be adjusted as provided in subsection (1) (b) (ii) of this section.

(c) Until July 1, 1993, the total compensation for all unspecified permanent partial disabilities resulting from the same injury shall not exceed the sum of ninety thousand dollars. Beginning on July 1, 1993, total compensation for all unspecified permanent partial disabilities resulting from the same injury shall not exceed a sum calculated as follows:

(i) Beginning on July 1, 1993, the sum shall be increased to one hundred eighteen thousand eight hundred dollars; and

(ii) Beginning on July 1, 1994, and each July 1 thereafter, the sum prescribed in (b)(i) of this subsection shall be adjusted as provided in subsection (1)(b)(ii) of this section.

(4) If permanent partial disability compensation is followed by permanent total disability compensation, any portion of the permanent partial disability compensation which exceeds the amount that would have been paid the injured worker if permanent total disability compensation had been paid in the first instance, shall be deducted from the pension reserve of such injured worker and his or her monthly compensation payments shall be reduced accordingly.

(5) Should a worker receive an injury to a member or part of his or her body already, from whatever cause, permanently partially disabled, resulting in the amputation thereof or in an aggravation or increase in such permanent partial disability but not resulting in the permanent total disability of such worker, his or her compensation for such partial disability shall be adjudged with regard to the previous disability of the injured member or part and the degree or extent of the aggravation or increase of disability thereof.

(6) When the compensation provided for in subsections (1) through (3) of this section exceeds three times the average monthly wage in the state as computed under the provisions of RCW 51.08.018, payment shall be made in monthly payments in accordance with the schedule of temporary total disability payments set forth in RCW 51.32.090 until such compensation is paid to the injured worker in full, except that the first monthly payment shall be in an amount equal to three times the average monthly wage in the state as computed under the provisions of RCW 51.08.018, and interest shall be paid at the rate of eight percent on the unpaid balance of such compensation commencing with the second monthly payment. However, upon application of the injured worker or survivor the monthly payment may be converted, in whole or in part, into a lump sum payment, in which event the monthly payment shall cease in whole or in part. Such conversion may be made only upon written application of the injured worker or survivor to the department and shall rest in the discretion of the department depending upon the merits of each individual application. Upon the death of a worker all unpaid installments accrued shall be paid according to the payment schedule established prior to the death of the worker to the widow or widower, or if there is no widow or widower surviving, to the dependent children of such claimant, and if there are no such dependent children, then to such other dependents as defined by this title.

(7) Awards payable under this section are governed by the schedule in effect on the date of injury.

RCW 51.32.100
Preexisting disease.

If it is determined that an injured worker had, at the time of his or her injury, a preexisting disease and that such disease delays or prevents complete recovery from such injury, it shall be ascertained, as nearly as possible, the period over which the injury would have caused disability were it not for the diseased condition and the extent of permanent partial disability which the injury would have caused were it not for the disease, and compensation shall be awarded only therefor.

RCW 51.32.110
Medical examination – Refusal to submit – Traveling expenses – Pay for time lost.

(1) Any worker entitled to receive any benefits or claiming such under this title shall, if requested by the department or self-insurer, submit himself or herself for medical examination, at a time and from time to time, at a place reasonably convenient for the worker and as may be provided by the rules of the department. An injured worker, whether an alien or other injured worker, who is not residing in the United States at the time that a medical examination is requested may be required to submit to an examination at any location in the United States determined by the department or self-insurer.

(2) If the worker refuses to submit to medical examination, or obstructs the same, or, if any injured worker shall persist in unsanitary or injurious practices which tend to imperil or retard his or her recovery, or shall refuse to submit to such medical or surgical treatment as is reasonably essential to his or her recovery or refuse or obstruct evaluation or examination for the purpose of vocational rehabilitation or does not cooperate in reasonable efforts at such rehabilitation, the department or the self-insurer upon approval by the department, with notice to the worker, may suspend any further action on any claim of such worker so long as such refusal, obstruction, non-cooperation, or practice continues and reduce, suspend, or deny any compensation for such period: PROVIDED That the department or the self-insurer shall not suspend any further action on any claim of a worker or reduce, suspend, or deny any compensation if a worker has good cause for refusing to submit to or to obstruct any examination, evaluation, treatment or practice requested by the department or required under this section.

(3) If the worker necessarily incurs traveling expenses in attending the examination pursuant to the request of the department, such traveling expenses shall be repaid to him or her out of the accident fund upon proper voucher and audit or shall be repaid by the self-insurer, as the case may be.

(4) (a) If the medical examination required by this section causes the worker to be absent from his or her work without pay: (i) in the case of a worker insured by the department, the worker shall be paid compensation out of the accident fund in an amount equal to his or her usual wages for the time lost from work while attending the medical examination; or (ii) in the case of a worker of a self-insurer, the self-insurer shall pay the worker an amount equal to his or her usual wages for the time lost from work while attending the medical examination.

(b) This subsection (4) shall apply prospectively to all claims regardless of the date of injury.

RCW 51.32.112
Medical examination – Standards and criteria – Special medical examinations by chiropractors – Compensation guidelines and reporting criteria.

(1) The department shall develop standards for the conduct of special medical examinations to determine permanent disabilities, including, but not limited to:

(a) The qualifications of persons conducting the examinations;

(b) The criteria for conducting the examinations, including guidelines for the appropriate treatment of injured workers during the examination; and

(c) The content of examination reports.

(2) Within the appropriate scope of practice, chiropractors licensed under chapter 18.25 RCW may conduct special medical examinations to determine permanent disabilities in consultation with physicians licensed under chapter 18.57 or 18.71 RCW. The department, in its discretion, may request that a special medical examination be conducted by a single chiropractor if the department determines that the sole issues involved in the examination are within the scope of practice under chapter 18.25 RCW. However, nothing in this section authorizes the use as evidence before the board of a chiropractor's determination of the extent of a worker's permanent disability if the determination is not requested by the department.

(3) The department shall investigate the amount of examination fees received by persons conducting special medical examinations to determine permanent disabilities, including total compensation received for examinations of department and self-insured claimants, and establish compensation guidelines and compensation reporting criteria.

(4) The department shall investigate the level of compliance of self-insurers with the requirement of full reporting of claims information to the department, particularly with respect to medical examinations, and develop effective enforcement procedures or recommendations for legislation if needed.

RCW 51.32.114
Medical examination – Department to monitor quality and objectivity.
The department shall examine the credentials of persons conducting special medical examinations and shall monitor the quality and objectivity of examinations and reports for the department and self-insured claimants. The department shall adopt rules to ensure that examinations are performed only by qualified persons meeting department standards.

RCW 51.36.060
Duties of attending physician or licensed advanced registered nurse practitioner – Medical information.
Physicians or licensed advanced registered nurse practitioners examining or attending injured workers under this title shall comply with rules and regulations adopted by the director, and shall make such reports as may be requested by the department or self-insurer upon the condition or treatment of any such worker, or upon any other matters concerning such workers in their care. Except under RCW 49.17.210 and 49.17.250, all medical information in the possession or control of any person and relevant to the particular injury in the opinion of the department pertaining to any worker whose injury or occupational disease is the basis of a claim under this title shall be made available at any stage of the proceedings to the employer, the claimant's representative, and the department upon request, and no person shall incur any legal liability by reason of releasing such information.

RCW 51.36.070
Medical examination – Reports – Costs.
Whenever the director or the self-insurer deems it necessary in order to resolve any medical issue, a worker shall submit to examination by a physician or physicians selected by the director, with the rendition of a report to the person ordering the examination. The department or self-insurer shall provide the physician performing an examination with all relevant medical records from the worker's claim file. The director, in his or her discretion, may charge the cost of such examination or examinations to the self-insurer or to the medical aid fund as the case may be. The cost of said examination shall include payment to the worker of reasonable expenses connected therewith.

Regulations (WACs)

In addition to the regulations presented next, refer to WACs 296-20-230 through 296-20-660 (Category Rating System for cervical, cardiac, urologic impairment, etc.) in Section V. These regulations are specific to impairment and, therefore, listed there, not below.

WAC 296-14-300
Mental condition/mental disabilities.
(1) Claims based on mental conditions or mental disabilities caused by stress do not fall within the definition of an occupational disease in RCW 51.08.140.

Examples of mental conditions or mental disabilities caused by stress that do not fall within occupational disease shall include, but are not limited to, those conditions and disabilities resulting from:

(a) Change of employment duties;
(b) Conflicts with a supervisor;
(c) Actual or perceived threat of loss of a job, demotion, or disciplinary action;
(d) Relationship with supervisors, coworkers, or the public;
(e) Specific or general job dissatisfaction;
(f) Work load pressures;
(g) Subjective perceptions of employment conditions or environment;
(h) Loss of job or demotion for whatever reason;
(i) Fear of exposure to chemicals, radiation, biohazards, or other perceived hazards;
(j) Objective or subjective stresses of employment;
(k) Personnel decisions;
(l) Actual, perceived, or anticipated financial reversals or difficulties occurring to the businesses or self-employed individuals or corporate officers.

(2) Stress resulting from exposure to a single traumatic event will be adjudicated with reference to RCW 51.08.100.

WAC 296-20-19000
What is a permanent partial disability award?

Permanent partial disability is any anatomic or functional abnormality or loss after maximum medical improvement (MMI) has been achieved. At MMI, the worker's condition is determined to be stable or nonprogressive at the time the evaluation is made. A permanent partial disability award is a monetary award designed to compensate the worker for the amputation or loss of function of a body part or organ system. Impairment is evaluated without reference to the nature of the injury or the treatment given. To ensure uniformity, consistency and fairness in rating permanent partial disability, it is essential that injured workers with comparable anatomic abnormalities and functional loss receive comparable disability awards. As such, the amount of the permanent partial disability award is not dependent upon or influenced by the economic impact of the occupational injury or disease on an individual worker. Rather, Washington's Industrial Insurance Act requires that permanent partial disability be established primarily by objective physical or clinical findings establishing a loss of function. Mental health impairments are evaluated under WAC 296-20-330 and 296-20-340.

WAC 296-20-19010
Are there different types of permanent partial disabilities?

Under Title 51 RCW, there are two types of permanent partial disabilities.

(1) Specified disabilities are listed in RCW 51.32.080 (1) (a). They are limited to amputation or loss of function of extremities, loss of hearing or loss of vision.

(2) Unspecified disabilities include, but are not limited to, internal injuries, back injuries, mental health conditions, respiratory disorders, and other disorders affecting the internal organs.

WAC 296-20-19020
How is it determined which impairment rating system is to be used to rate specified and unspecified disabilities?

(1) Specified disabilities are rated in one of two ways:

(a) Impairment due to amputation, total loss of hearing, and total loss of vision are rated according to RCW 51.32.080;

(b) Impairment for the loss of function of extremities, as well as partial loss of hearing or vision, is rated using a nationally recognized impairment rating guide unless otherwise precluded by department rule.

(2) Unspecified disabilities are rated in accordance with WAC 296-20-200 through 296-20-660.

WAC 296-20-19030
To what extent is pain considered in an award for permanent partial disability?

The categories used to rate unspecified disabilities incorporate the worker's subjective complaints. Similarly, the organ and body system ratings in the AMA *Guides to the Evaluation of Permanent Impairment* incorporate the worker's subjective complaints. A worker's subjective complaints or symptoms, such as a report of pain, cannot be objectively validated or measured. There is no valid, reliable or consistent means to segregate the worker's subjective complaints of pain from the pain already rated and compensated for in the conventional rating methods. When rating a worker's permanent partial disability, reliance is primarily placed on objective physical or clinical findings that are independent of voluntary action by the worker and can be seen, felt or consistently measured by examiners. No additional permanent partial disability award will be made beyond what is already allowed in the categories and in the organ and body system ratings in the AMA guides.

For example:

- Chapter 18 of the 5th Edition of the AMA *Guides to the Evaluation of Permanent Impairment* attempts to rate impairment caused by a patient's pain complaints. The impairment caused by the worker's pain complaints is already taken into consideration in the categories and in the organ and body system ratings in the AMA guides. There is no reliable means to segregate the pain already rated and compensated from the pain impairment that Chapter 18 purports to rate. Chapter 18 of the 5th Edition of the *Guides to the Evaluation of Permanent Impairment* cannot be used to calculate awards for permanent partial disability under Washington's Industrial Insurance Act.

WAC 296-20-200
General information for impairment rating examinations by attending doctors, consultants or independent medical examination (IME) providers.

(1) The department of labor and industries has promulgated the following rules and categories to provide a comprehensive system of classifying unspecified permanent partial disabilities in the proportion they reasonably bear to total bodily impairment. The department's objectives are to reduce litigation and establish more certainty and uniformity in the rating of unspecified permanent partial disabilities pursuant to RCW 51.32.080(2).

(2) The following system of rules and categories directs the provider's attention to the actual conditions found and establishes a uniform system for conducting rating examinations and reporting findings and conclusions in accord with broadly accepted medical principles.

The evaluation of bodily impairment must be made by experts authorized to perform rating examinations. After conducting the examination, the provider will choose the appropriate category for each bodily area or system involved in the particular claim and include this information in the report. The provider will, therefore, in addition to describing the worker's condition in the report, submit the conclusions as to the relative severity of the impairment by giving it in terms of a defined condition rather than a personal opinion as to a percentage figure. In the final section of this system of categories and rules are some rules for determining disabilities and the classification of disabilities in bodily impairment is listed for each category. These last provisions are for the department's administrative use in acting upon the expert opinions which have been submitted to it.

(3) In preparing this system, the department has complied with its duty to enact rules classifying unspecified disabilities in light of statutory references to nationally recognized standards or guides for determining various bodily impairments. Accordingly, the department has obtained and acted upon sound established medical opinion in thus classifying unspecified disabilities in the reasonable proportion they bear to total bodily impairment. In framing descriptive language of the categories and in assigning a percentage of disability, careful consideration has been given to nationally recognized medical standards and guides. Both are matters calling for the use of expert medical knowledge. For this reason, the meaning given the words used in this set of categories and accompanying rules, unless the text or context clearly indicates the contrary, is the meaning attached to the words in normal medical usage.

(4) The categories describe levels of physical and mental impairment. Impairment is anatomic or functional abnormality or loss of function after maximum medical improvement has been achieved. This is the meaning of "impairment" as the word is used in the guides mentioned above. This standard applies to all persons equally, regardless of factors other than loss of physical or mental function. Impairment is evaluated without reference to the nature of injury or the treatment therefore, but is based on the functional loss due to the injury or occupational disease. The categories have been framed to include conditions in other bodily areas which derive from the primary impairment. The categories also include the presence of pain, tenderness and other complaints. Workers with comparable loss of function thus receive comparable awards.

(5) These rules and categories (WAC 296-20-200 through 296-20-690) shall only be applicable to compensable injuries occurring on or after the effective date of these rules and categories.

(6) These rules and categories (WAC 296-20-200 through 296-20-690) shall be applicable only to cases of permanent partial disability. They have no applicability to determinations of permanent total disability.

WAC 296-20-2010
General rules for impairment rating examinations by attending doctors and consultants.

These general rules must be followed by doctors who perform examinations or evaluations of permanent bodily impairment.

(1) Impairment rating examinations shall be performed only by doctors currently licensed in medicine and surgery (including osteopathic and podiatric) or dentistry, and department-approved chiropractors subject to RCW 51.32.112. The department or self-insurer may request the worker's attending doctor conduct the impairment rating when appropriate. If the attending doctor is unable or unwilling to perform the impairment rating examination, a consultant, at the attending doctor's request, may conduct a consultation examination and provide an impairment rating based on the findings. The department or self-insurer can also request an impairment rating examination from an independent medical examiner (IME) provider. A chiropractic impairment rating examination may be performed only when the worker has been clinically managed by a chiropractor.

(2) Whenever an impairment rating examination is made, the attending doctor or consultant must complete a rating report that includes, at the minimum, the following:

(a) Statement that the patient has reached maximum medical improvement (MMI) and that no further curative treatment is recommended;

(b) Pertinent details of the physical examination performed (both positive and negative findings);

(c) Results of any pertinent diagnostic tests performed (both positive and negative findings). Include copies of any pertinent tests or studies ordered as part of the exam;

(d) An impairment rating consistent with the findings and a statement of the system on which the rating was based (for example, the AMA *Guides to the Evaluation of Permanent*

Impairment and edition used, or the Washington state category rating system—refer to WAC 296-20-19000 through 296-20-19030 and WAC 296-20-200 through 296-20-690); and

(e) The rationale for the rating, supported by specific references to the clinical findings, especially objective findings and supporting documentation including the specific rating system, tables, figures and page numbers on which the rating was based.

(3) It is the responsibility of attending doctors and consultants to be familiar with the contents of the *Medical Examiner Handbook* section on how to rate impairment.

(4) Attending doctors and consultants performing impairment ratings must be available and willing to testify on behalf of the department or self-insurer, worker or employer and accept the department fee schedule for testimony.

(5) A complete impairment rating report must be sent to the department or self-insurer within fourteen calendar days of the examination date, or within fourteen calendar days of receipt of the results of any special tests or studies requested as a part of the examination. Job analyses (JAs) sent to the IME provider at the time of the impairment rating exam must be completed and submitted with the impairment rating report.

WAC 296-20-2015
What rating systems are used for determining an impairment rating conducted by the attending doctor or a consultant?

The following table provides guidance regarding the rating system generally used. These rating systems or others adopted through department policies should be used to conduct an impairment rating.

Overview of Systems for Rating Impairment

Rating System	Used for These Conditions	Form of the Rating
RCW 51.32.080	Specified disabilities: Loss by amputation, total loss of vision or hearing	Supply the level of amputation
AMA Guides to the Evaluation of Permanent Impairment	Loss of function of extremities, partial loss of vision or hearing	Determine the percentage of loss of function, as compared to amputation value listed in RCW 51.32.080
Category Rating System	Spine, neurologic system, mental health, respiratory, taste and smell, speech, skin, or disorders affecting other internal organs	Select the category that most accurately indicates overall impairment
Total Bodily Impairment (TBI)	Impairments not addressed by any of the rating systems above, and claims prior to 1971	Supply the percentage of TBI

WAC 296-20-2025
May a worker bring someone with them to an impairment rating examination conducted by the attending doctor or a consultant?

(1) Workers can bring an adult friend or a family member to the impairment rating examination to provide comfort and reassurance. The accompanying person may attend the physical examination but may not attend a psychiatric examination.

(2) The accompanying person cannot be compensated for attending the examination by anyone in any manner.

(3) The worker may not bring an interpreter to the examination. If interpretive services are needed, the department or self-insurer will provide an interpreter.

(4) The purpose of the impairment rating examination is to provide information to assist in the determination of the level of any permanent impairment, not to conduct an adversarial procedure. Therefore, the accompanying person cannot be:

(a) The worker's attorney, paralegal, any other legal representative, or any other personnel employed by the worker's attorney or legal representative; or

(b) The worker's attending doctor, any other provider involved in the worker's care, or any other personnel employed by the attending doctor or other provider involved in the worker's care.

The department may designate other conditions under which the accompanying person is allowed to be present during the impairment rating examination.

WAC 296-20-2030
May the worker videotape or audiotape the impairment rating examination conducted by the attending doctor or a consultant?

The use of recording equipment of any kind by the worker or accompanying person is not allowed.

WAC 296-20-220
Special rules for evaluation of permanent bodily impairment

(1) Evaluations of permanent bodily impairment using categories require uniformity in procedure and terminology. The following rules have been enacted to produce this uniformity and shall apply to all evaluations of permanent impairment of an unspecified nature.

(a) Gradations of relative severity shall be expressed by the words "minimal," "mild," "moderate" and "marked" in an ascending scale. "Minimal" shall describe deviations from normal responses which are not medically

significant. "Mild," "moderate" and "marked" shall describe ranges of medically significant deviations from normal responses. "Mild" shall describe the least severe third. "Moderate" shall describe the middle third. "Marked" shall describe the most severe third.

(b) "Permanent" describes those conditions which are fixed, lasting and stable, and from which within the limits of medical probability, further recovery is not expected.

(c) "Impairment" means a loss of physical or mental function.

(d) "Total bodily impairment," as used in these rules, is the loss of physical or mental function which is essentially complete short of death.

(e) The examiner shall not assign a percentage for permanent bodily impairment described in the categories established herein.

(f) The method of evaluating impairment levels is by selection of the appropriate level of impairment. These descriptive levels are called "categories." Assessments of the level of impairment are to be made by comparing the condition of the injured workman with the conditions described in the categories and selecting the most appropriate category.

These rules and categories for various bodily areas and systems provide a comprehensive system for the measurement of disabling conditions which are not already provided for in the list of specified permanent partial disabilities in RCW 51.32.080(1). Disabilities resulting from loss of central visual acuity, loss of an eye by enucleation, loss of hearing, amputation or loss of function of the extremities will continue to be evaluated as elsewhere provided in RCW 51.32.080.

The categories have been classified in percentages in reasonable proportion to total bodily impairment for the purpose of determining the proper award. Provision has been made for correctly weighing the overall impairment due to particular injuries or occupational disease in cases in which there are preexisting impairments.

(g) The categories of the various bodily areas and systems are listed in the order of increasing impairment except as otherwise specified. Where several categories are given for the evaluation of the extent of permanent bodily impairment, the impairments in the higher numbered categories, unless otherwise specified, include the impairments in the lesser numbered categories. No category for a condition due to an injury shall be selected unless that condition is permanent as defined by these rules.

The examiner shall select the one category which most accurately indicates the overall degree of permanent impairment unless otherwise instructed. Where there is language in more than one category which may appear applicable, the category which most accurately reflects the overall impairment shall be selected.

The categories include appropriate subjective complaints in an ascending scale in keeping with the severity of objective findings, thus a higher or lower category is not to be selected purely on the basis of unusually great or minor complaints.

(h) When the examination discloses a preexisting permanent bodily impairment in the area of the injury, the examiner shall report the findings and any category or impairment appropriate to the worker's condition prior to the industrial injury in addition to the findings and the categories appropriate to the worker's condition after the injury.

(i) Objective physical or clinical findings are those findings on examination which are independent of voluntary action and can be seen, felt, or consistently measured by examiners.

(j) Subjective complaints or symptoms are those perceived only by the senses and feelings of the person being examined which cannot be independently proved or established.

(k) Muscle spasm as used in these rules is an involuntary contraction of a muscle or group of muscles of a more than momentary nature.

(l) An involuntary action is one performed independently of the will

(m) These special rules for evaluation of permanent bodily impairment shall apply to all examinations for the evaluation of impairment, in accordance with RCW 51.32.080, for the body areas or systems covered by or enumerated in WAC 296-20-230 through 296-20-660.

(n) The rules for evaluation of each body area or system are an integral part of the categories for that body area or system.

(o) In cases of injury or occupational disease of bodily areas and/or systems which are not included in these categories or rules and which do not involve loss of hearing, loss of central visual acuity, loss of an eye by enucleation or loss of the extremities or use thereof, examiners shall determine the impairment of such bodily areas and/or systems in terms of percentage of total bodily impairment.

(p) The words used in the categories of impairments, in the rules for evaluation of specific impairments, the general rules, and the special rules shall be deemed, unless the context indicates the contrary, to have their general and accepted medical meanings.

(q) The rating of impairment due to total joint replacement shall be in accordance with the limitation of motion guidelines as set forth in the Guides to the Evaluation of Permanent Impairment of American Medical Association, with department of labor and industries acknowledgement of responsibility for failure of prostheses beyond the seven year limitation.

WAC 296-21-270
Psychiatric Services

The following rules supplement information contained in the fee schedules regarding coverage and reimbursement for psychiatric services.

Treatment of mental conditions to workers is to be goal directed, time limited, intensive, and limited to conditions caused or aggravated by the industrial condition. Psychiatric services to workers are limited to those provided to psychiatrists and licensed psychologists, and according to department policy. For purposes of this rule, the term "psychiatric" refers to treatment by psychologists as well as psychiatrists.

Initial evaluation, and subsequent treatment must be authorized by department staff, as outlined by department policy. The report of initial evaluation, including test results, and treatment plan are to be sent to the worker's attending provider, as well as the department. A copy of sixty-day narrative reports to the department is also to be sent to the attending provider.

All providers are bound by the medical aid rules in chapter 296-20 WAC. Reporting requirements are defined in chapter 296-20 WAC. In addition, the following are required: Testing results with scores, scales, and profiles; report of raw data sufficient to allow reassessment by a panel or independent medical examiner. Use of the current Diagnostic and Statistical Manual of the American Psychiatric Association axis format in the initial evaluation and sixty-day narrative reports, and explanation of the numerical scales are required.

A report to the department will contain, at least, the following elements:

Subjective complaints;
Objective observations;
Assessment of the worker's condition and goals accomplished; and
Plan of care.

The codes, reimbursement levels, and other policies for psychiatric services are listed in the fee schedules.

WAC 296-23-302
Definitions

Direct patient care. For the purpose of meeting the qualifications of an independent medical examination (IME) provider, direct patient care means face-to-face contact with the patient for the purpose of evaluation and management of care that includes, but is not limited to:

- History taking and review of systems;
- Physical examination;
- Medical decision making;
- Coordination of care with other providers and agencies.

This does not include time spent in consultation or independent medical examinations.

Impairment rating examination. An examination to determine whether or not the injured/ill worker has any permanent impairment(s) as a result of the industrial injury or illness after the worker has reached maximum medical improvement. An impairment rating may be a component of an IME.

Independent medical examination (IME). An objective medical examination requested by the department or self-insurer to establish medical facts about a worker's physical condition.

Independent medical examination (IME) provider. A firm, partnership, corporation or individual doctor who has been approved and given an independent medical examination (IME) provider number by the department to perform IMEs.

Medical director. A licensed doctor in the firm, partnership, corporation or other legal entity responsible to provide oversight on quality of independent medical examinations, impairment ratings and reports.

Medical examiners' handbook. A handbook distributed by the department containing department policy and information to assist doctors who perform independent medical examinations and impairment rating examinations.

Provider number. A unique number(s) assigned to a provider by the department of labor and industries. The number identifies the provider and is linked to a tax identification number that has been designated by the provider for payment purposes. A provider may have more than one provider number assigned by the department.

WAC 296-23-307
Why are independent medical examinations requested?

Independent medical examinations (IMEs) are requested by the department or the self-insurer. Generally, IMEs are ordered for one or more of the following reasons, including, but not limited to:

(1) Establish a diagnosis;

(2) Outline a program of treatment;

(3) Evaluate what, if any, conditions are related to the claimed industrial injury or occupational disease/illness;

(4) Determine whether an industrial injury or occupational disease/illness has aggravated a

preexisting condition and the extent or duration of that aggravation;

(5) Establish when the accepted industrial injury or occupational disease/illness has reached maximum medical improvement;

(6) Establish an impairment rating;

(7) Evaluate whether the industrial injury or occupational disease/illness has worsened; or

(8) Evaluate the worker's mental and/or physical restrictions as well as the worker's ability to work.

WAC 296-23-312
Can a provider conduct independent medical examinations (IMEs) for the department or self-insurer without an active IME provider number from the department?

No. Only doctors who possess an active IME provider number can provide independent medical examinations for the department or self-insurer. Providers must submit an IME provider application and be approved by the department to receive this number.

WAC 296-23-317
What qualifications must a provider meet to receive an independent medical examination (IME) provider number?

In order to ensure high quality independent medical examinations, the department shall only approve an IME provider number for persons, firms, partnerships, corporations or other legal entities that meet the following qualification requirements:

(1) Providers who wish to bill or get paid for independent medical examinations or related services must apply for and receive an IME provider number. Issuance of an IME provider number does not guarantee IME referrals.

(2) Providers must have and maintain a current license to practice in the state in which they conduct IMEs and meet at least one of the two following requirements:

(a) Board certification in their medical specialty; or

(b) A minimum of an average of eight hours per week over the past two years of direct patient care in their medical specialty (excluding IMEs).

(3) Only providers in the following specialties who meet all other requirements may perform IMEs;

	Doctors licensed To Practice:				
Examiner is:	Medicine & surgery	Osteopathic Medicine & surgery	Podiatric Medicine & surgery	Chiropractic	Dentistry
In Washington	Yes	Yes	Yes	Yes	Yes
Not in Washington	Yes	Yes	Yes	No	Yes

(4) A provider licensed to practice chiropractic in Washington must also meet all the following requirements:

(a) Be a chiropractic consultant for the department for at least two years;

(b) Take an impairment rating course approved by the department; and

(c) Attend the department's chiropractic consultant and examiners' seminar during the twenty-four months prior to application.

(5) Business requirements:

(a) Providers must conduct independent medical examinations only in a professional office suitable for medical, dental, podiatric, chiropractic or psychiatric examinations where the primary use of the examination site is for medical services; not residential, commercial, educational or retail in nature. The site must have, at a minimum, adequate access, climate control, light, space and equipment to provide for the comfort and safety of the injured/ill worker and provide the privacy necessary for workers to discuss their medical issues.

(b) Providers must comply with all federal and state laws, regulations and other requirements with regard to business operations, including specific requirements for business operations for the provision of medical services.

(c) Providers must have a private disrobing area and adequate provision of examination gowns.

(d) Providers must have telephone answering capability during regular business hours, Monday through Friday, in order to facilitate scheduling of independent medical examinations and means for workers to contact the provider regarding their scheduled examination. If the office is open on Saturday, telephone access must be available.

(e) In order to be assigned an IME provider number, an IME firm, partnership, corporation or other legal entity must have a medical director. The medical director must be a licensed provider and be responsible to provide oversight on the quality of independent medical examinations, impairment ratings and reports.

WAC 296-23-322
What boards are recognized by the department for independent medical examination (IME) provider approval?

The department accepts certifications from boards recognized by the following as meeting the board certification requirements in WAC 296-23-317:

(1) American Board of Medical Specialties;

(2) American Osteopathic Association (AOA) Bureau of Osteopathic Specialties;

(3) American Podiatric Medical Association;

(4) American Dental Association.

WAC 296-23-327
What other factors may the department's medical director consider in approving or disapproving an application for an independent medical examination (IME) provider number?

The department's medical director considers other factors in approving or disapproving an IME application, including, but not limited to, the following:

(1) Complaints about the provider;

(2) Quality of reports;

(3) Timeliness of reports;

(4) Charges regarding any crime, gross misdemeanor, felony or violation of statutes or rules by any administration agency, court or board;

(5) Convictions of any crime, gross misdemeanor, felony or violation of statutes or rules by any administrative agency, court or board.

WAC 296-23-332
What are the requirements for notifying the department or self-insurer if an independent medical examination (IME) provider has a change in status?

Providers must immediately notify the department of any change in status that might affect their qualifications for an independent medical examination (IME) provider number. The notification must be in writing. Providers must include a copy of any charges or final orders if applicable. Changes in status include, but are not limited to:

(1) Changes in time spent in direct patient care;

(2) Loss or restriction of hospital admitting or practice privileges;

(3) Changes affecting business requirements (WAC 296-23-317);

(4) Loss of board certification;

(5) Charges regarding any crime, gross misdemeanor, felony or violation of statutes or rules by any administrative agency, court or board;

(6) Convictions of any crime, gross misdemeanor, felony or violation of statutes or rules by any administrative agency, court or board;

(7) Temporary or permanent probation, suspension, revocation, or limitation placed on their license to practice by any court, board, or administrative agency in any state or foreign jurisdiction.

WAC 296-23-337
What factors does the department's medical director consider in suspending or terminating an independent medical examination (IME) provider number?

The department's medical director may consider several factors in suspending or terminating an IME provider number. Examples include, but are not limited to:

(1) Complaints about the provider;

(2) Disciplinary proceedings or actions;

(3) Proceedings in any court dealing with the provider's professional conduct, quality of care and criminal actions;

(4) Ability to effectively convey and substantiate medical opinions and conclusions concerning workers;

(5) Untimely reports;

(6) Substandard quality of reports or failure to comply with current department policy on report contents;

(7) Unavailability or lack of willingness to responsibly communicate with the department or self-insurer;

(8) Unavailability or lack of willingness to testify on behalf of the department or self-insurer, worker, or employer;

(9) Failure to stay current in the area of specialty and in the areas of impairment rating, performance of IMEs, industrial injury and occupational disease/ illness, industrial insurance statutes, regulations and policies;

(10) Failure to continue to maintain the criteria to be an IME provider;

(11) Misrepresentation of information provided to the department;

(12) Failure to inform the department of changes affecting the provider's status as an IME provider;

(13) Failure to comply with the department's orders, statutes, rules, or policies; and

(14) Failure to accept the department fee schedule rate for testimony or independent medical examinations.

WAC 296-23-342
Are providers entitled to referrals from the department or self-insurer?

No. The department or self-insured employer refers industrially injured or ill workers for independent medical examination (IME) services at their sole discretion. No provider is entitled to referrals from the referral source.

WAC 296-23-347
What are the independent medical examination (IME) provider's responsibilities in an examination?

(1) The IME provider's responsibilities prior to the examination are to:

(a) Be familiar with the contents of the medical examiner's handbook;

(b) Review all claim documents provided by the department or self-insured employer;

(c) Contact the worker prior to the examination to confirm the appointment date, time and location; and

(d) Review the purpose of the examination and the questions to be answered in the examination report.

(2) The IME provider's responsibilities during the examination are to:

(a) Introduce himself or herself to the worker;

(b) Verify the identity of the worker;

(c) Let the worker know that the claim documents from the department or self-insurer have been reviewed;

(d) Explain the examination process and answer the worker's questions about the examination process;

(e) Advise the worker that he/she should not perform any activities beyond their physical capabilities;

(f) Allow the worker to remain fully dressed while taking the history;

(g) Ensure adequate draping and privacy if the worker needs to remove clothing for the examination;

(h) Refrain from expressing personal opinions about the worker, the employer, the attending doctor, or the care the worker has received;

(i) Conduct an examination that is unbiased, sound and sufficient to achieve the purpose and reason the examination was requested;

(j) Conduct the examination with dignity and respect for the worker;

(k) Ask if there is any further information the worker would like to provide; and

(l) Close the examination by telling the worker that the examination is over.

(3) The IME provider's responsibilities following the examination are to:

(a) Send a complete IME report to the department or self-insurer within fourteen calendar days of the examination date, or within fourteen calendar days of the receipt of the results of any special tests or studies requested as a part of the examination. Reports received after fourteen calendar days may be paid at a lower rate per the fee schedule. The report must meet the requirements of WAC 296-23-382; and

(b) The claim file information received from the department or self-insurer should be disposed of in a manner used for similar health records containing private information after completion of the IME or any follow-up test results are received. IME reports should be retained per WAC 296-20-02005.

WAC 296-23-352
Must the independent medical examination (IME) provider address job analyses (JAs) at the request of the department or self-insurer?

Job analyses (JAs) sent to the IME provider at the time of the IME referral must be completed and submitted with the IME report. JAs submitted within sixty calendar days after the IME must be completed and returned within fourteen days of receipt of the JAs.

WAC 296-23-357
May an independent medical examination (IME) provider offer to provide ongoing treatment to the worker?

No. However, if a worker voluntarily approaches an IME provider who has previously examined the worker and asks to be treated by that provider, the provider can treat the worker. The provider must document that the worker was aware of other treatment options.

WAC 296-23-362
May a worker bring someone with them to an independent medical examination (IME)?

(1) Workers can bring an adult friend or family member to the IME to provide comfort and reassurance. That accompanying person may attend the physical examination but may not attend a psychiatric examination.

(2) The accompanying person cannot be compensated for attending the examination by anyone in any manner.

(3) The worker may not bring an interpreter to the examination. If interpretive services are needed, the department or self-insurer will provide an interpreter.

(4) The purpose of the IME is to provide information to assist in the determination of the level of any permanent impairment not to conduct an adversarial procedure. Therefore, the accompanying person cannot be:

(a) The worker's attorney, paralegal, any other legal representative, or any other personnel employed by the worker's attorney or legal representative; or

(b) The worker's attending doctor, any other provider involved in the worker's care, or any other personnel employed by the attending doctor or other provider involved in the worker's care.

The department may designate other conditions under which the accompanying person is allowed to be present during the IME.

WAC 296-23-367
May the worker videotape or audiotape the independent medical examination?

The use of recording equipment of any kind by the worker or accompanying person is not allowed.

WAC 296-23-372
Can a worker file a complaint about a provider's conduct during an independent medical examination?

Workers can send written complaints about a provider's conduct during an independent medical examination to the self-insurer or department. Based on the nature of the complaint, the department may refer the complaint to the department of health.

WAC 296-23-377
If an independent medical examination (IME) provider is asked to do an impairment rating examination only, what information must be included in the report?

When doing an impairment rating examination, the IME provider must first review the determination by the attending doctor that the worker has reached maximum medical improvement (MMI).

(1) If, after reviewing the records, taking a history from the worker and performing the examination, the IME provider concurs with the attending doctor's determination of MMI, the impairment rating report must, at a minimum, contain the following:
   (a) A statement of concurrence with the attending doctor's determination of MMI;
   (b) Pertinent details of the physical or psychiatric examination performed (both positive and negative findings);
   (c) Results of any pertinent diagnostic tests performed (both positive and negative findings). Include copies of pertinent tests with the report;
   (d) An impairment rating consistent with the findings and a statement of the system on which the rating was based (for example, the AMA *Guides to the Evaluation of Permanent Impairment* and edition used, or the Washington state category rating system—refer to WAC 296-20-19000 through 296-20-19030 and WAC 296-20-200 through 296-20-690); and
   (e) The rationale for the rating, supported by specific references to the clinical findings, especially objective findings and supporting documentation including the specific rating system, tables, figures and page numbers on which the rating was based.

(2) If, after review of the records, a history from the worker and the examination, the IME provider does not concur with the attending doctor's determination of MMI, an IME report must be completed. (See WAC 296-23-382.)

WAC 296-23-381
What rating systems are used for determining an impairment rating conducted by an independent medical examination (IME) provider?

The following table provides guidance regarding the rating systems generally used. These rating systems or others adopted through department policies should be used to conduct an impairment rating.

Overview of Systems for Rating Impairment

Rating System	Used for These Conditions	Form of the Rating
RCW 51.32.080	Specified disabilities: Loss by amputation, total loss of vision or hearing	Supply the level of amputation
AMA *Guides to the Evaluation of Permanent Impairment*	Loss of function of extremities, partial loss of vision or hearing	Determine the percentage of loss of function, as compared to amputation value listed in RCW 51.32.080
Category Rating System	Spine, neurologic system, mental health, respiratory, taste and smell, speech, skin, or disorders affecting other internal organs	Select the category that most accurately indicates overall impairment
Total Bodily Impairment (TBI)	Impairments not addressed by any of the rating systems above, and claims prior to 1971	Supply the percentage of TBI

WAC 296-23-382
What information must be included in an independent medical examination (IME) report?

(1) It is the department's intention to purchase objective examinations to ensure that sure and certain determinations are made of all benefits to which the worker might be entitled. The independent medical examination report must:
   (a) Contain objective, sound and sufficient medical information;
   (b) Document the review of the claim documents provided by the department or self-insurer;
   (c) Document the worker's history and the clinical findings;

(d) Answer all the written questions posed by the department or self-insurer or include a description of what would be needed to address the questions;

(e) Include objective conclusions and recommendations supported by underlying rationale that links the medical history and clinical findings;

(f) Be in compliance with current department reporting policies; and

(g) Be signed by the IME provider performing the examination.

(2) An impairment rating report may be requested as a component of an IME. Impairment rating reports are to be done as specified in WAC 296-20-200 and 296-20-2010 (2) (a) through (e) and 296-23-377.

WAC 296-23-387
What are the responsibilities of an independent medical examination (IME) provider regarding testimony?

IME providers must make themselves reasonably available to testify at the board of industrial insurance appeals or by deposition. In signing the application to be an independent medical examination provider, the provider agrees to perform examinations and be available to testify and to answer questions about the medical facts of the case at rates established under the authority of Washington industrial insurance law. Failure to comply with this requirement may result in termination of the IME provider number.

WAC 296-23-392
Is there a fee schedule for independent medical examinations (IMEs)?

The maximum fee schedule for performing independent medical examinations is published by the department in the Medical Aid Rules and Fee Schedules available from the department.

Appendix D
Department of Labor and Industries Local Service Centers

Region 1
Northwest Washington

Bellingham
1720 Ellis St, Suite 200
98225-4647
360-647-7300

Everett
729 100th St SE
98208-3727
425-290-1300

Mount Vernon
525 E College Way, Suite H
98273-5500
360-416-3000

Region 2
King County

Bellevue
616 120th Ave NE, Suite C201
98005-3037
425-990-1400

Seattle
315 5th Ave South, Suite 200
98104-2607
206-515-2800

Tukwila
12806 Gateway Dr
PO Box 69050 (for mail)
98168-1050
206-835-1000

Region 3
Pierce County/Peninsula

Bremerton
500 Pacific Ave, Suite 400
98337-1943
360-415-4000

Port Angeles
1605 E Front St, Suite C
98362-4628
360-417-2700

Tacoma
950 Broadway, Suite 200
98402-4453
253-596-3800

Region 4
Southwest Washington

Aberdeen
415 West Wishkah, Suite 1B
PO Box 66
98520-4315
360-533-8200

Longview
900 Ocean Beach Hwy
98632-4013
360-575-6900

Tumwater
(Olympia mailing address)
7273 Linderson Way SW
PO Box 44850
98504-4850
360-902-5799

Vancouver
312 SE Stonemill Dr, Suite 120
98684-3508
360-896-2300

Region 5
Central Washington

East Wenatchee
519 Grant Road
98802-5459
509-886-6500

Kennewick
4310 W. 24th Ave
98338
509-735-0100

Moses Lake
3001 W. Broadway Ave
98837-2907
509-764-6900

Okanogan
1234 2nd Ave S
98840-9723
509-826-7345

Walla Walla
1815 Portland Ave, Suite 2
99362-2246
509-527-4437

Yakima
15 W Yakima Ave, Suite 100
98902-3480
509-454-3700

Region 6
Eastern Washington

Colville
298 S Main, Suite 203
99114-2416
509-684-7417

Pullman
1250 Bishop Blvd SE, Suite G
PO Box 847
99163-0847
509-334-5296

Spokane
901 N Monroe St, Suite 100
99201-2149
509-324-2600

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Useful Addresses and Numbers

1. IME reports for State Fund

Department of Labor & Industries
PO Box 44239
Olympia, WA 98504-4239

2. IME bills for State Fund

Department of Labor & Industries
PO Box 44269
Olympia, WA 98504-4269

3. IME reports and bills for self-insurers

Use address on IME assignment letter

4. General information about self-insurers

Department of Labor & Industries
Self-Insurance Section
PO Box 44892
Olympia, WA 98504-4892

5. IME reports and bills for crime victims

Department of Labor & Industries
Crime Victims Section
PO Box 44520
Olympia, WA 98504-4520

6. Questions about State Fund billing

Provider Toll-Free Line: 1-800-848-0811
Online Claim and Account Center
www.ClaimInfo.LNI.wa.gov

7. Application information, updates, IME complaints

Department of Labor & Industries
Provider Review & Education Unit
PO Box 44322
Olympia, WA 98504-4322
Phone: 360-902-6822
Web page for Independent Medical Examinations
www.IMEs.LNI.wa.gov

8. Seminars and trainings on IMEs, impairment rating and other topics

Department of Labor & Industries
Provider Education Coordinator
PO Box 44322
Olympia, WA 98504-4322
phone: 360-902-6817 fax: 360-902-4249
e-mail: mdan235@LNI.wa.gov

9. Assistance with IMEs and impairment ratings

IME Project Manager
phone: 360-902-6818
e-mail: brit235@LNI.wa.gov

10. Order the AMA Guides to the Evaluation of Permanent Impairment

Order Department
American Medical Association
PO Box 109050
Chicago, Illinois 60610-9050
Phone: 1-800-621-8335

11. Order L&I publications (e.g., Attending Doctor's Handbook, Medical Examiners' Handbook)

Labor & Industries Warehouse
PO Box 44843
Olympia, WA 98504-4843 **OR**
Provider Toll Free Line: 1-800-848-0811

12. L&I web sites

L&I web site, main page
www.LNI.wa.gov

Web page for Independent Medical Examinations including report template
www.IMEs.LNI.wa.gov

Find an Approved IME examiner
www.IMEs.LNI.wa.gov/
then click on "Find a Medical Examiner."

Main web page for providers
www.LNI.wa.gov/ClaimsIns/Providers

Topic page that includes links to Provider Bulletins and the Medical Treatment Guidelines
www.LNI.wa.gov/Main/ProviderTopics.asp

Direct link to treatment information
www.LNI.wa.gov/ClaimsIns/Providers/Treatment/default.asp

Online Claim and Account Center
www.ClaimInfo.LNI.wa.gov

13. Suggestions to improve this handbook

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